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Closing Campaign for the Grading Committee Fund

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THE Nurses' Committee for Financing the Grading Plan hereby submits to the nurses of the country a report of its status to date and the program for completing the campaign as voted upon by the Boards of Directors of the three National Nursing Associations at their 1930 January meeting.

The Committee was created, as will be recalled, at a joint session in January, 1927, and was charged with the responsibility of raising such funds as were necessary toward the financing of the five-year program of the Grading Committee. In September, 1927, the Committee launched its initial campaign, naming as its objective $100,000.

By January 1, 1929, the Committee had received subscriptions amounting to $[illegible] and measures were considered for completing the fund. It was unanimously agreed that since all states were equally affected by the Grading Committee program, and would equally share in its benefits, a plan should be adopted whereby all states would have the opportunity to participate equally in financing the work. Accordingly, the Boards of Directors of the three National Nursing Associations made quota assignments to the states upon the basis of their membership in the American Nurses' Association. To the $100,000 objective, $10,000 was added to allow for campaign costs and possible shrinkage, the sum apportioned to the states thus being $110,000. The quota tables were published in the March, 1929, *American Journal of Nursing*, and reprints sent to each State Association. By January 1, 1930, the Committee had received subscriptions totalling $73,346.38.

The five-year program of the Grading Committee terminates in December, 1931. Approximately twenty-two months remain for closing the campaign. With this fact in mind, the Boards of Directors of the three National Nursing Associations, at their recent meeting in January, voted *to instruct the Committee to set as a time limit for completing the fund, June, 1930, either through pledges or through cash subscriptions.*

The Committee asks that all pledges be paid in full by the end of June, 1931. June, 1931, is fixed for final payments on pledges in order to assure the necessary funds for the last six months of the Grading Committee work.

Table 1 in this report shows, by

TABLE 1—NURSES' COMMITTEE FOR FINANCING GRADING PLAN

Cash Receipts Including Payments on Pledges, and Pledges from Individual Nurses and Nursing Organizations by States to January 1, 1930

States	Individual Nurses	State Nurses' Assns.		District Assn.		Alumnae Assns.		State Leagues		Local Leagues		State Public Health Nurs. Assns.		Visiting Nurse Assns.		Misc. Assns.	Totals
		No.	Cont. & Pledge	No.	Cont. & Pledge	No.	Cont. & Pledge	No.	Cont. & Pledge	No.	Cont. & Pledge	No.	Cont. & Pledge	No.	Cont. & Pledge		
Alabama	$48.00	1	$471.81	1	$76.50	4	$205.00										$801.31
Arizona	13.00																13.00
Arkansas	59.00	1	191.65	3	40.00							1	$5.00				295.65
California	458.40	1	50.00	15	544.00	17	845.00	1	$175.00			1	25.00				2,097.40
Colorado	107.10	1	50.00			6	325.00	1	50.00	1	$5.00						537.10
Connecticut	168.00	1	35.00			10	255.00									Student Gov. Assn. $5.00	463.00
Delaware	17.00	1	168.86			1	50.00										235.86
District of Columbia	111.00	1	823.22			3	345.00	1	50.00								1,329.22
Florida	50.00	1	35.00	2	75.00	1	10.00										170.00
Georgia	71.00	1	100.00	3	335.00	11	300.00	1	25.00								831.00
Idaho	12.00	1	25.00														37.00
Illinois	512.50	1	3,380.17	10	179.00	24	2,850.00	1	960.00								7,881.67
Indiana	82.00	1	1,373.14	3	225.00	6	172.00	1	100.00								1,952.14
Iowa	116.00	1	1,260.00	11	600.00	19	455.00	1	40.00								2,471.00
Kansas	49.00	1	75.00	5	450.00	4	60.00	1	75.00								709.00
Kentucky	51.00					2	50.00	1	50.00			1	10.00				161.00
Louisiana	81.10	1	500.00	6	504.00	6	205.00	1	50.00								1,340.10
Maine	58.00			1	50.00	3	50.00										158.00
Maryland	165.50	1	457.25			4	425.00					1	25.00				1,072.75
Massachusetts	587.60	1	2,731.10	9	245.00	44	2,777.00	1	300.00								6,640.70
Michigan	241.50	1	1,330.00	9	555.00	10	445.00	1	125.00								2,696.50
Minnesota	165.10	1	150.00	3	850.00	20	839.00	1	125.00			1	25.00				2,154.10
Mississippi	21.00	1	334.36														355.36
Missouri	147.00	1	625.00	5	260.00	4	94.00	1	100.00	2	100.00						1,326.00
Montana	33.00			5	90.00												123.00
Nebraska	111.10	1	375.00	3	358.00	2	20.00	1	50.00	1	30.00						944.10
Nevada	3.00																3.00
New Hampshire	43.00	1	250.00			4	85.00										378.00
New Jersey	212.00	1	1,516.00	4	400.00	11	460.00	1	100.00								2,688.00
New Mexico	10.00	1	75.00														85.00
New York	1,314.50	1	2,500.00	12	3,286.05	43	4,939.50	1	530.00	2	360.00			1	$10.00		12,940.05
North Carolina	86.00	1	704.16	7	300.00	4	140.00	1	50.00								1,280.16
North Dakota	18.00	1	85.00					1	50.00								153.00
Ohio	327.00	1	200.00	7	463.50	20	728.00							3	25.00		1,743.50
Oklahoma	47.00			1	25.00			1	75.00								147.00
Oregon	44.20	1	125.00	3	70.00	2	42.00	1	50.00			1	25.00				356.20
Pennsylvania	817.60	1	2,000.00	5	757.00	43	1,360.50	1	150.00	1	50.00						5,135.10
Rhode Island	78.00	1	500.00			7	400.00	1	300.00			1	125.00				1,403.00
South Carolina	37.00			5	90.00												127.00
South Dakota	30.00			1	25.00	1	5.00										60.00
Tennessee	37.00	1	800.00	3	315.00	2	125.00										1,277.00
Texas	122.05	1	2,739.36	6	155.00	3	55.00	1	75.00								3,146.41
Utah	33.10	1	224.80			2	55.00										312.90
Vermont	31.00	1	25.00			1	5.00										61.00
Virginia	99.00					3	105.00									Va. State Ex. Board $500	704.00
Washington	107.00	1	125.00	9	334.00	3	85.00	1	20.00								671.00
West Virginia	41.00	1	125.00			1	10.00										176.00
Wisconsin	172.00			12	920.00	14	932.00	1	35.00	1	145.00	1	10.00				2,214.00
Wyoming	12.00			1	25.00												37.00
Midwest Division																100.00	100.00
Unknown	.10															5.00	5.10
Foreign	57.00																57.00
Grand Totals	$7,388.45	37	$26,604.88	169	$13,272.05	364	$20,896.00	26	$3,600.00	8	$690.00	8	$250.00	4	$35.00	3 $610.00	$73,346.38*

*Total cash receipts to Jan. 1, 1930 .... $48,658.83
Outstanding in Pledges $24,687.55

TABLE 2—HOW STATES HAVE MET THEIR QUOTAS FOR FINANCING THE GRADING PLAN TO JANUARY 1, 1930

States	1928 Membership A. N. A.	Quota of $110,000 on Basis of 1928 A. N. A. Membership	Total Cash Receipts and Pledges to Jan. 1, 1930	†Per Capita Membership Subscription on Basis of Cash Receipts and Pledges to Jan. 1, 1930
*Alabama	481	$756.31	$801.31	$1.67
Arizona	139	218.56	13.00	.09
Arkansas	400	628.95	295.65	.74
California	5,280	8,302.12	2,097.40	.40
Colorado	680	1,069.21	537.10	.79
Connecticut	1,860	2,924.61	463.00	.25
*Delaware	150	235.86	235.86	1.57
*District of Columbia	839	1,319.22	1,329.22	1.58
Florida	892	1,402.56	170.00	.19
Georgia	785	1,234.31	881.00	1.12
Idaho	84	132.08	37.00	.44
*Illinois	4,797	7,542.67	7,881.67	1.64
*Indiana	1,225	1,926.16	1,953.14	1.59
‡Iowa	1,607	2,526.80	2,471.00	1.54
Kansas	745	1,171.42	709.00	.95
Kentucky	558	877.38	161.00	.29
Louisiana	1,013	1,592.81	1,340.10	1.32
Maine	482	757.88	158.00	.33
Maryland	1,578	2,481.20	1,072.75	.68
*Massachusetts	4,058	6,380.69	6,640.70	1.64
Michigan	2,856	4,490.69	2,626.50	.92
Minnesota	2,410	3,789.42	2,154.10	.89
*Mississippi	226	355.36	355.36	1.57
Missouri	1,990	3,129.02	1,326.00	.67
Montana	171	268.88	123.00	.72
Nebraska	799	1,256.33	944.10	1.18
Nevada	30	47.17	3.00	.10
New Hampshire	394	619.51	378.00	.96
New Jersey	2,028	3,188.77	2,688.00	1.32
New Mexico	73	114.78	85.00	1.16
New York	9,765	15,354.21	13,540.05	1.39
*North Carolina	776	1,220.16	1,280.16	1.65
North Dakota	185	290.89	153.00	.83
Ohio	4,271	6,715.60	1,843.50	.43
Oklahoma	443	696.56	147.00	.33
Oregon	650	1,098.19	356.20	.54
Pennsylvania	7,473	11,750.34	5,665.10	.76
*Rhode Island	658	1,034.62	1,498.00	2.27
South Carolina	287	451.27	127.00	.44
South Dakota	143	224.85	50.00	.35
*Tennessee	805	1,265.76	1,277.00	1.59
*Texas	1,947	3,061.41	3,146.41	1.62
*Utah	199	312.90	312.90	1.57
Vermont	256	402.53	61.00	.24
Virginia	710	1,116.38	704.00	.99
Washington	1,138	1,789.36	671.00	.59
West Virginia	405	636.81	176.00	.43
*Wisconsin	1,166	1,833.39	2,214.00	1.90
Wyoming	42	66.04	37.00	.88

*States which have subscribed or oversubscribed their quotas.
†Per capita membership assignment by quota $1.57.
‡States which have subscribed or oversubscribed their quotas since January 1, 1930.

states, contributions and pledges received to January 1, 1930. In Table 2, the present status of each state is given with respect to its quota apportionment; the states' pledges and cash payments as a whole (fourth column) and the subscriptions on a per capita membership basis (fifth column). The American Nurses' Association membership in Table 2 is that upon which the quotas were assigned in March, 1929.

Thirteen states have either pledged or paid their quotas in full. They are *Alabama, Delaware, District of Columbia, Illinois, Indiana, Massachusetts, Mississippi, North Carolina, Rhode Island, Tennessee, Texas, Utah, and Wisconsin.* Of these thirteen states, ten have *exceeded* their quotas. (See

Table 2, starred states.) The state assignment according to per capita membership is $1.57, the state subscription according to per capita membership at the time of this report ranges from $.09 to $2.27, with Rhode Island in the lead.

When the Chairman of the Nurses' Committee for Financing the Grading Program presented the status of the Committee with its total contributions and pledges of $73,346.38 (Table 1) to the Boards of the three National Nursing Associations at their recent January joint session, the members of the Boards were unanimous in expressing their enthusiasm and appreciation of the splendid response by the nurses of the country. The belief was also expressed that those states which have not as yet acknowledged and pledged their quotas are considering plans to meet these quotas and that their acknowledgments have been deferred, pending the completion of such plans.

The Committee has now before it the job of completing the campaign, as far as pledges are concerned, by June, 1930, so that it may report to the Boards at the Milwaukee Convention that their instructions have been carried out and that the fund is assured. The Committee also looks forward with great satisfaction and pleasure to announcing at the Convention that the $110,000 goal has been achieved, and that every state has contributed generously and shared equally in financing the most significant and probably the most far-reaching project yet undertaken by the nursing profession.

Why Join?

A TELLING illustration of the value of belonging to your professional group is the following:

A local nurse desired membership in a society where the applications for membership are very carefully scrutinized. The Membership Committee, when considering her application, discovered that she was a nurse and one of the members said: "I will go to the nursing headquarters and get her record there. That will be worth so much more to us than the endorsement of persons we do not know." When she learned that this nurse was not known at headquarters and was not a member of her alumnae or the local nursing association, this committee member said, "I think I shall recommend the rejection of her application. I would feel, personally, that a nurse not a member of her own association was likely questionable." As a matter of fact, this nurse is in every way eligible and desirable for membership in any organization.

Membership in, and endorsement of your own professional organization is your best recommendation.—*The Michigan Nurse.*

The Massachusetts League of Nursing Education

THE Massachusetts League of Nursing Education is offering a course in Principles of Teaching. It includes eight lectures by Mr. Howard Wilson, instructor in the Harvard Graduate School of Education on The Learner, The Learning Process, The Laws of Learning, Memorizing and Forming Habits, Learning to Solve Problems, Generalizing from Experience, Forming Interests and Ideals and Supervising and Directing the Learner. Four hundred have registered for the course. We shall eagerly await reports of the results, as a stimulus to us all to seek cooperation with educational institutions where they are available.

First Aid Treatment of Skull Fractures

A. V. de NEVEU, M.D.

THE subject of the treatment of skull fractures has many debatable theories, suggestions and angles. Different authorities who have made a study, or who have occasion to observe a large number of skull or head injuries, differ somewhat as to the proper method of treatment. One fact that is quite evident, and stands out as a generally accepted change in the treatment of skull fractures, is the reduced number of radical operations. But a few years ago skull fractures were operated upon promiscuously; today the conservative surgeon hesitates to perform the decompression operation which was so universally used, except in a certain few cases when it is evident that no other method will suffice. I mean by "a certain few cases" such conditions as the depressed fracture, or when a state of coma and other accompanying symptoms, such as gradual slowing of the pulse, rise of blood pressure and of temperature, supervene after a period of negative symptoms, and less radical treatment has failed after a reasonable period.

Another method of treatment that has been seriously questioned by some authorities is the spinal puncture, used as treatment, and it is questioned by some even as a source of diagnosis. I believe it is quite unnecessary to dwell upon the fact that each skull fracture is a problem in itself and, after observing certain common-sense rules, one must treat the case as its individuality necessitates. The Johnston Emergency Hospital has had, in the last few years, an average of from 140 to 170 skull fractures a year. These have been treated by the house and staff surgeons. The treatment is quite uniform and very few cases are subjected to a radical operation. The cases entering the hospital have a wide range of symptoms, from those who have no apparent symptoms upon entrance and develop them within twenty-four to forty-eight hours, to the patients with badly depressed fracture, or those who are dead upon entrance.

I shall try to classify the cases in a general way as to type of injury and method of treatment. In the first class, we have the alcoholic, and this class is numerous. In many instances it is difficult to differentiate between alcoholism and skull fracture, or concussion, or alcoholism with skull fracture. On entrance to the receiving room, the temperature, pulse and blood pressure are taken; the patient is examined for contusions, lacerations or hematomata of the head, these being present in many cases of alcoholism, and some patients having a skull fracture with little or no discernible injury. These injuries have no real significance, except to put one on guard, and the patient is kept for observation. Further examination is made as to bleeding from ears or nose, and the equality or reaction to light of the pupils. The reflexes are observed. These examinations being negative, the patient is put "top bed" in the "alcoholic" ward and a "top bed" note sheet is started, the pulse and temperature are charted and the patient is observed for twenty four hours. (*Note:* By "top bed" is meant that the patient's clothes are loosened, not removed entirely, and he is placed between blankets, but not put to bed.)

If any of the above-mentioned symptoms are noted, or if the patient

has an increased temperature, a slow pulse, or an increased blood pressure, or is vomiting, he is put to bed with a "fifteen-minute" pulse chart started and is treated as a possible skull fracture. The patient is carefully observed and if, within the next few hours, he shows any unfavorable symptoms, the case is classified as a skull fracture and further examination and treatment are given. I will here state that opiates are withheld unless the patient is suffering severe pain from other injuries, or is in great shock; in such cases, the patient is treated for shock.

Patients are also brought to the hospital who are unconscious, who are not definitely alcoholic, but who have an alcoholic breath, or who are unconscious and have not been drinking but are unconscious from some other cause, when prompt diagnosis is desirable. Among the more common causes would be shock from injury, hysteria with or without injury—as also the epileptiform unconsciousness, drug poisons, acute or chronic disease, as meningitis, or acute symptoms of the disease, or nephritis, diabetes, improper dosage of insulin, apoplexy, or delirium tremens. These all may have head injuries and very careful observation is necessary. Many chronic alcoholics develop delirium tremens with skull fracture, as they do also with other injuries or an illness.

A diagnosis of skull fracture may be difficult for the first few hours, as we may have a concussion or laceration of brain tissue, with hemorrhage into the brain, without a fracture, or the patient may have some other condition simulating skull fracture. One then must use all means of diagnosis at his command, first, with the physical findings and observation of symptoms and second, by spinal puncture.

I have given as the first classification of skull fracture cases, the alcoholic type; second, the type sometimes confused with other conditions causing semi-consciousness or coma; and third, I would give the patient who has definite symptoms of skull fracture, but who is not unconscious. A spinal puncture may be necessary making this diagnosis, or possibly an x-ray picture. The x-ray is very valuable in the diagnosis of skull injury, but the negative picture does not mean that there is no skull fracture present; especially when there is a basal fracture or a fracture through the frontal or orbital regions, the x-ray may be easily misinterpreted. The only value is in the positive picture and, unless one is an experienced roentgenologist, a diagnosis by the x-ray, in lieu of other symptoms, is not satisfactory.

The treatment in these cases consists of giving magnesium sulphate, one or two ounces by mouth, or two or three ounces by rectum, with one drachm of camphorated tincture of opium, placing ice caps to head, moist sterile dressings to lacerations or to ears (if patient is decompressing through these sources), and heat to the body, the bed being placed in semi-moderate Fowler's position.

Twenty cc. of 10 per cent solution of magnesium sulphate is also given intravenously at hourly intervals for three to four doses and later, if found necessary, doses of glucose, 20 cc. of 50 per cent to 100 per cent solution, repeated at six-hour intervals until symptoms subside or more radical treatment is instituted. If the symptoms should then become serious, a spinal puncture is resorted to, which, in many cases, helps to alleviate these unfavorable symptoms. (*Note:* A urine examination is necessary on all cases, taken a few hours

from time of entrance to determine whether sugar is present, especially when glucose is given.)

The next type is the unconscious patient who enters the hospital with definite symptoms of skull fracture. This patient is generally put to bed in a low Fowler's position, magnesium sulphate is given intravenously or by rectum, as well as other restorative treatment used in skull fractures, such as treatment of shock, or hemorrhage, temporary splinting of other fractures or dressing of wounds. The temperature, pulse and blood pressure are taken at fifteen-minute intervals for two hours. In many of these cases, a spinal puncture is made to assist in a definite diagnosis or to relieve pressure, although as a diagnostic measure we also must consider that we have blood in the spinal fluid in other cases than skull fractures, as alcoholism, delirium tremens, back injuries, or in traumatism of tissues in making the spinal puncture. This last may be obviated by taking the fluid in two test tubes and by comparison of the color. If from traumatic tissue or punctured vessel outside of spinal canal, the first tube is generally more bloody and a clot will quickly form. (*Note:* It is important to keep the patient flat on his back for a period of time after spinal puncture.)

In this type, when other symptoms besides coma are not marked, the spinal puncture is withheld for a time, to determine whether the patient will recover consciousness without this method of treatment.

In the fifth class I include the depressed fracture, and I wish to subdivide this group into two classes. First, those who are in such a degree of shock from this injury, or other injuries, that surgical interference would cause death and, second, the other type, where surgery is positively essential to the recovery of the patient. The patient in these cases being in coma, or semi-coma, little or no anesthesia may be necessary and a decompression operation is performed. The patient is returned to bed and treated as other postoperative cases, and the general routine care given skull fractures is administered.

Another type of skull fracture, or rather another phase of the course of the illness, is the development within a few days of meningitis. I mention this because a patient may remain in the Emergency Hospital for a few days and develop this symptom and a spinal fluid examination should be made and proper treatment instituted, after laboratory examination of the fluid to determine what type of anti-meningococcic serum is to be given.

In cases where there is bleeding from the nose, mouth or ear, aseptic measures should be taken to prevent infection from entering through these channels, and care should be taken not to enter the ear canal with the probe, or applicator, as one may carry in an infection.

There are many details of treatment, or of methods of treatment, or of diagnosis, which I have omitted but, in a rather generalised statement on the subject, it would not be practical to go into further details in the "emergency treatment." But there are a few important points to be observed. The most important is that all head injuries, as contusions, lacerations or hematomata, should be observed for from twenty-four to forty-eight hours, as we must consider them as potential skull or brain injuries.

In all cases when a symptom of skull injury has developed, the patient, especially if a child, should be kept in bed for a period of weeks rather than days. The food should

be given with a view to avoiding gastrointestinal disturbances, nose and throat should be cleansed, the bowels kept active, and the patient under observation by a physician.

Another important point to remember is that skull fracture, in itself, means nothing as to symptoms or treatment. This condition may exist without any appreciable symptoms being noted, and the type of treatment is in relation to the symptoms of the degree of injury, or laceration, to the brain substance.

And lastly, it is better to have the patient's life first in our thought and to consider treatment very carefully. Use all available means of diagnosis, treat shock and try to keep that spark of life alive, and do not be too hasty in using the more radical treatment of skull fractures.

Nursing Care of Skull Fracture and Concussions

CHARLOTTE C. CROSSLEY, R. N.

IN dealing with the care of patients with skull fractures, the nurse has to consider the probable extent of the injury, *i. e.*, (1) the degree of injury to the skull, whether simple, compound, linear, or depressed, (2) injury to the brain tissue, (3) injury to the blood vessels of the brain. The treatment is governed by these conditions.

However, on admittance to the hospital, the exact degree of injury may not be definitely known by the surgeon and he is able to make his final diagnosis from the x-ray pictures and from the symptoms which the patient may later manifest. Thus, it is most important that the nurse observe, chart, and report immediately every symptom which would help in this diagnosis.

Injuries to the skull may be classified under the following headings:

I. Concussion, with or without a fracture of skull.

II. Depressed fracture, with the possible complication of intracranial pressure due to
   - (a) Injury to brain tissue.
   - (b) Hemorrhage from ruptured blood vessels.
   - (c) Fragments of bone.

The symptoms which indicate the condition of concussion are: stupor, or the loss of consciousness, varying in time from a few minutes to two or three days; the pulse feeble and thready; the respirations shallow; the skin cold and clammy; the pupils regular and equal and, usually, contracted; the temperature is subnormal and the blood pressure lowered. The patient frequently responds to outside stimuli such as a loud voice. The treatment for a patient in this condition is absolute rest in bed, in the prone position with the head very slightly raised. (Some surgeons wish the head kept on a level with the body.) The head is kept immobilized by the use of sand bags to allow healing of the fractured bone. The light of the room should be subdued, as bright light and noise are usually irritating to the patient. Liquid and semiliquid nourishment is given, if the nurse is able to arouse the patient sufficiently to get him to swallow. Otherwise, infusions of glucose, 5 per cent, and normal saline are given to supply nourishment and fluids to the body. An ice cap is kept on the head. The

patient must be kept under close observation for any change in the symptoms, and it is most important that the nurse observe any change in the blood pressure, the pulse rate, the pupils of the eyes, and the respirations. If there is any evidence of vomiting, coma, or convulsions, it should be reported at once and the temperature, pulse, respiration, and blood pressure should be taken every two hours. These should be recorded, with any other change in the physical symptoms.

Due to a disturbance in circulation in the brain, the patient may have involuntary escape of feces and urine. The nurse, then, has to use extreme care to prevent irritation of the skin, keeping it as clean and dry as possible and massaging the bony prominences to prevent decubitus acutus.

As the condition begins to clear, the patient may vomit or become quite restless and irritable, and it may be found necessary to use restraint.

During convalescence the patient may complain a great deal of headache or have spells of depression and show slight signs of mental disturbance.

When there is intracranial pressure, this compression may be due to pressure by fragments of bone, hemorrhage from an injured blood vessel, or edema. The symptoms which the nurse must watch for and which are indicative of this condition are the following: the pulse is quite slow; the respirations are stertorous, often of the Cheyne-Stokes type; the pupils of the eyes are dilated, may be unequal in size, and do not respond to light; the optic nerve is edematous, causing a choked disc; the temperature may be elevated; and there is an increase in the blood pressure and in the spinal fluid pressure. Other sensory organs may be impaired. There may be hemorrhage from the ear, discharge from the nose, or protrusion of the eye. Convulsions of a part of the body may occur. Frequently, the bladder or the sphincter of the rectum is paralyzed and the patient is unable to void or has involuntary escape of feces.

As the compression increases in the brain, paralysis in different parts of the body may develop and the location of the paralysis and the other physical symptoms, with the x-ray picture, help the surgeon to determine the exact center of the brain injured or under compression. Hence, any development of these symptoms should be noted and charted and the nurse should then take the temperature, pulse, respiration, and blood pressure of the patient every two hours. If there is an increase in the spinal fluid pressure, a lumbar puncture is done, using a manometer, bringing the pressure down to normal. This treatment is repeated in twelve hours if the pressure continues. To decrease the blood pressure, magnesium sulphate, 6 ounces of 50 per cent solution, is given every six hours per rectum or 1 ounce of 50 per cent solution every three hours by mouth. Glucose, 100 cc. of 50 per cent solution, is also given slowly, intravenously, and this is repeated in six hours, if necessary.

The surgeon may deem it necessary to perform a decompression operation to remove the pieces of bone or the blood clots and to ligate bleeding vessels.

The nursing care follows that for patients with concussion, with special attention to alleviate conditions existing when intracranial pressure occurs.

If the patient is unconscious, he must not be left alone. When there is any discharge from the nose it should be cleansed with saline irrigation, having another nurse hold the head of the patient, or with cotton applicators if the patient is unconscious.

This should be done often enough to keep the nose clean. If there is hemorrhage from the ears they should be cleansed with mild saline solution and cotton applicators and small pledgets of cotton left in the ears. If there is any evidence of paralysis of the bladder the patient should be catheterized. The patient is kept in the prone position with the head level with the body and immobilized by the use of sand bags. An ice cap is applied to the head. The nurse must chart all defecations, as it is important to have free elimination. An enema is given every day, if necessary, unless the patient is incontinent. If this latter condition exists, the nurse must exercise great diligence in the care of the skin, to prevent abrasions and to keep the patient clean and comfortable. By changing the position of the patient every four hours, the pressure on the prominences is relieved and the danger of pneumonia is lessened.

The scalp wound is given routine aseptic care and the surgical dressings are done as for any surgical wound.

If the patient is conscious, he is allowed liquids, otherwise nourishment is supplied by glucose infusions.

To summarize, the symptoms a nurse should be on the alert to observe and the care she should give a patient with skull fracture are:

Symptoms:

1. Rise in temperature.
2. Changing of a weak, thready pulse to a very slow one.
3. Shallow respirations changing to irregular, stertorous type.
4. Increase in blood pressure.
5. Increase in pressure of the spinal fluid.
6. Hemorrhage from ears.
7. Discharge from nose.
8. Stupor, deepening to state of coma or unconsciousness.
9. Paralysis or convulsions of any part of the body.
10. Unequal pupils of the eyes or choked disc of eye.
11. Incontinence.
12. Retention of urine.

Treatment:

1. Keep patient absolutely quiet in dimly lighted room.
2. Have patient in prone position, immobilize the head with sand bags, and keep ice cap to head.
3. Keep patient scrupulously clean and dry, and prevent decubitus acutus.
4. See that proper body eliminations occur, catheterizing and giving enema as ordered.
5. Prevent pneumonia.
6. Restrain as needed.
7. Cleanse ears and nose of patient as needed, to keep free of discharges.
8. Take temperature, pulse, respiration, and blood pressure every two hours as long as intracranial pressure continues.
9. See that the patient receives enough nourishment to prevent acidosis.

The Public Health Nurse for March

Official Magazine of the National Organization for Public Health Nursing

(May be had in combination with the *Journal*)

Trail Blazing in Social Work. By Katharine D. Hardwick.

Some Aspects of the Child Health Program in Austria. By Hortense Hilbert.

Public Health Nursing Under the Englewood Plan. By Mary E. Edgecomb.

A Staff Club House—Detroit V. N. A.

Food Selection for Children. By Lydia J. Roberts.

Standing Orders for Health Education, Brooklyn, N. Y.

A Community Program in Mental Hygiene. By Stanley P. Davies.

Salvation through Work—The Altro Workshop. By Edward Hochhauser

Nurses in Commerce and Industry. By Louise M. Tattershall.

Service Norms and Their Variation—Part I. By Emma A. Winslow.

Report of the Ideal Magazine Committee.

Comparative Nursing Methods

Lumbar Puncture, Hypodermoclysis, and Intravenous Infusion Trays, Contributed by

WINIFRED WHITNEY, R.N.; MERLE WALKER, R.N., SALLY JOHNSON, R.N. and IRENE KELLY, R.N.

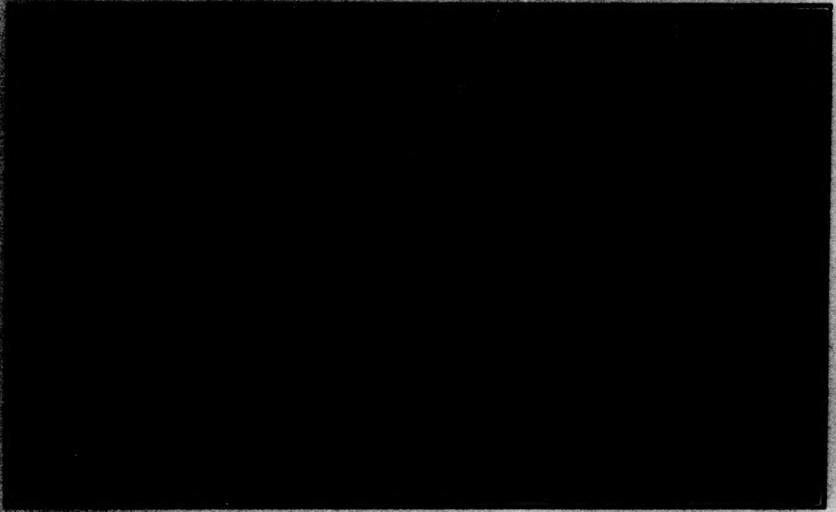


FIGURE 1

LUMBAR PUNCTURE TRAY USED IN THE SYDENHAM HOSPITAL, NEW YORK CITY

3 round glass-stoppered bottles, 2 oz., for iodin, alcohol and novocain
1 tube ethyl chloride
2 sterile test tubes for fluid
2 sterile lumbar puncture needles
1 Luer syringe, 20 cc. in sterile towel
2 Luer syringes, 2 cc. with needles, in glass container
1 sterile medicine glass
sterile applicators in test tubes
1 small white enamel container with sterile gauze sponges
2 sterile towels
1 pair sterile gloves
1 glass rod with assorted sizes of adhesive
1 manometer
1 white enamel cup to hold test tubes
(Size of tray, 20 by 11½ by 3)

ARE nurses interested in the way other nurses carry out procedures? Are they eager to know about new or different kinds of equipment? Are they lured on to new heights of inventiveness at seeing what some one else has evolved from her inner consciousness? The equipment for three different procedures as carried on in three different hospitals is shown here in the belief that they are.

The principles on which a treatment is based may not change, but their relative importance may. For instance, it was not formerly considered necessary to measure in millimeters the pressure of the spinal fluid as it flowed from the needle during a spinal puncture. But now that it is considered necessary to do so, in many cases, it is interesting to see the two types of manometers shown in Figures 1 and 2.

Figure 3

Lumbar Puncture Tray Used in the Massachusetts General Hospital, Boston, Mass.

1. Flexible collodion
2. Tincture of iodin
3. Alcohol 70 per cent
4. 2 per cent novocain
5. 3 sterile towels
6. 2 sterile sponges
7. Kidney basin
8. Cup containing 3 sterile test tubes
9. Adhesive
10. Sterile towel with:
    - 2 manometers
    - 3 sterile stoppers for test tubes
    - 3 lumbar puncture needles
    - 1 three-way stopcock
    - 1 2 cc. syringe with needle

The manometer shown in Figure 1 is based on the same principle as the mercury manometer commonly used in taking blood pressure. The spinal fluid trap (the connection between the needle and the manometer) is detached and sterilized in alcohol.

The manometer shown in Figure 2 consists of two hollow graduated glass rods with metal adaptors at the ends. The rods are numbered 1 and 2, fit into metal cases when not in use, and may be sterilized by boiling. After the lumbar puncture needle has been inserted, the three-way stopcock is attached to it and manometer 1 is inserted into the top opening of the stopcock. As the spinal fluid rises in the hollow manometer the degree of pressure may be read on the scale. If the pressure is too great to be recorded on the first manometer the scale may be lengthened by joining the second manometer to the first. The degree of pressure is then read on the second manometer.

Again, comparison of equipment calls forth a whole troop of questions. Would it be better to put up lumbar puncture, infusion, and other needles

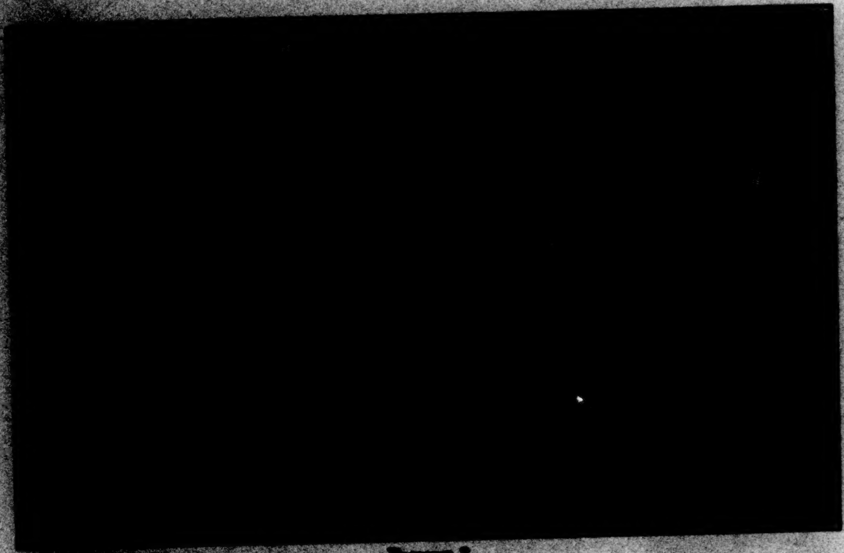


FIGURE 8

HYPODERMOCLYSIS TRAY USED IN THE SYDENHAM HOSPITAL, NEW YORK CITY

1 Kelly bottle, 700 cc., graduated
3 feet of rubber tubing (stethoscope)
1 glass connecting tube
1 glass Y-tube
2 glass Murphy regulators
2 needles, blunt end, 2¼"
1 needle, blunt end, 2"
2 metal adapters
2 pieces small size rubber tubing, 12" long, to fit adapters
1 small drum for sterile gauze sponges
3 round glass-stoppered bottles, 4 oz., for alcohol, iodin, and collodion
1 glass rod assorted sizes adhesive
1 small hemostat, straight
1 infusion thermometer
1 test tube for applicators
1 white enamel bowl, 6", for waste
2 sterile towels
1 pair sterile gloves
1 metal shut-off
1 glass jar on heavy base for dressing forceps
1 pair forceps, 5"
(Size of tray, 17½ by 12 by 2)

in test tubes, autoclave them, and keep them always ready, as in Figure 1; or to keep them unsterile when not in use and boil them when they are needed as in Figure 2; or to sterilise them after use, by boiling, dry them under aseptic conditions, wrap them, and keep them ready for next time?

Are cotton balls less costly and just as efficient as gauze sponges; and is it easier and cheaper to keep them in [illegible] jars as in Figure 1; or in [illegible] metal drums as in Figure 3; or to wrap them in bundles as in Figure 9? For hypodermoclysis, which is better from the standpoint of the patient's safety, of cost, ease of handling, and durability, the Kelly bottle shown in Figure 3 or the inverted flask hung up in its muslin holder in Figure 9? Shall the flasks for infusion be arranged so that the solution is siphoned off as in Figure 7, or is the gravity method better?

If a thermos bottle will keep a solution at the right temperature for an infusion, as in Figure 8, would there be any advantage in using it for hypodermoclyses and proctoclyses as well? Or, on the other hand, is this

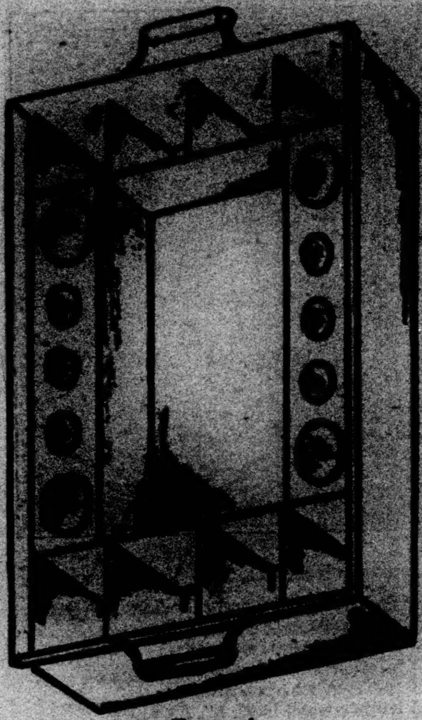


FIGURE 4

SPINAL PUNCTURE BASKET USED IN THE TRINITY LUTHERAN HOSPITAL, KANSAS CITY, MO.

Bottom section:
1. Long fiber cotton
2. Small lap sheet
3. Sterile towels
4. Sterile sponges

Left section:
1. Ethyl chloride
2, 3. Sterile spinal puncture needles
4. Ether

Top section, large:
1. Two sterile medicine glasses
2. Small jar applicators
3. Alcohol
4. Iodin

Right section:
1. Two cc. syringe
2. Sterile hypodermic needle in glass test tube
3. Novocain tablet in glass test tube
4. Adrenalin
5. Medicine dropper in sterile test tube

Center:
Assortment of sterile test tubes
(Basket of 24 gauge steel, 9½ by 13½ by 3)

HYPODERMOCLYSIS AND INTRAVENOUS INFUSION BASKET USED IN THE TRINITY LUTHERAN HOSPITAL, KANSAS CITY, MO.

Bottom section, large:
1. Sponges
2. Sterile towel
3. Small lap sheet

Bottom section, small:
1. Ether
2, 3, 4, 5, 6. Assortment of sterile needles in glass test tubes

Top section:
1. Ethyl chlorid
2. Sterile glycerin
3. Collodion
4. Aromatic spirits of ammonia
5. Adrenalin
6. Alcohol

Top section, large:
1. Sterile long fiber cotton
2. Small jar of sterile applicators
3. Adhesive tape
4. Iodin
5. Tourniquet

Center section:
Flasks with sterile saline, or sterile glucose
Hypodermoclysis flask with tubing
Intravenous infusion flask with tubing

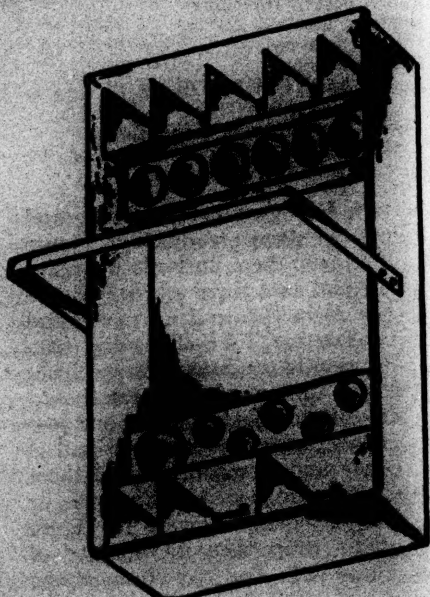


FIGURE 5

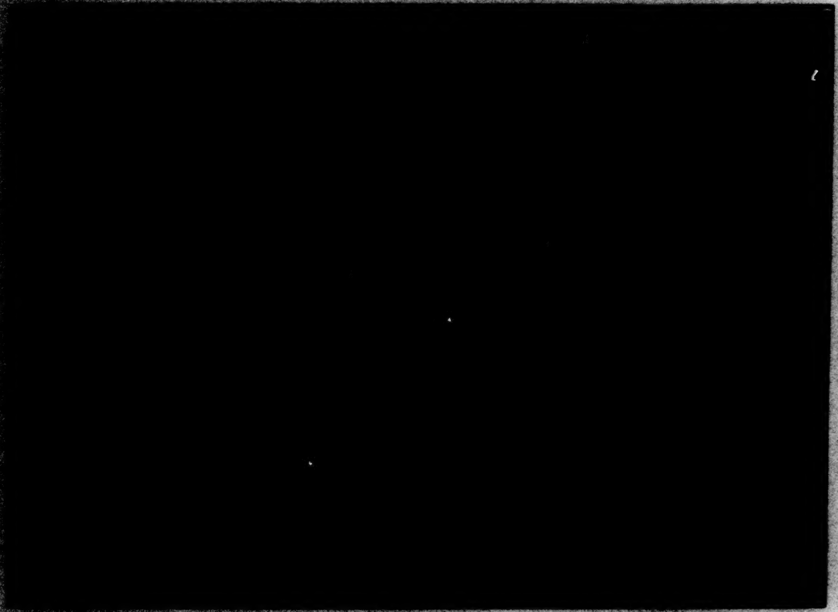


FIGURE 6

HYPODERMOCLYSIS TRAY USED IN THE ST. ALEXIS' HOSPITAL, CLEVELAND, OHIO

Flask (1,000 cc.) of prescribed solution, 115 degrees, F.
Rubber stopper supplied with two hollow glass tubes
1 piece of rubber tubing, 40 inches long and of proper bore, supplied with a stopcock and metal screw compressor. One end is attached to the short piece of hollow glass tube, the other is equipped with a Luer adapter.
Stopper, tubing and accessories are wrapped and autoclaved.
2 clysis needles
sterile gauze sponges
sterile cotton balls
2 sterile towels
sterile forceps
1 flask each of ether, alcohol 60 per cent, iodin 6 per cent and collodion
paper bag
two unsterile dressing towels
muslin cover for flask

advantage offset by the fact that it is impossible for doctor or nurse to see how much of the fluid has run out, at what rate it is flowing, and whether sediment or other foreign matter is present in the solution? And how is the solution to be kept hot after it leaves the container and begins its long journey to the patient?

Is it easier for stranger staff nurses and inexperienced students when the equipment for each procedure is kept ready assembled on individual trays? Or is the value of this system offset by the expense of having complete equipment for every procedure when parts of it could be used interchangeably? Is it a saving of time to have a tray for each procedure ready at all times? Or is an undue amount of time consumed in "checking up" equipment which is used infrequently? There is also the expense and time involved when infrequently used equipment is kept sterile and must be re-sterilized at stated intervals. How long does equipment remain sterile even when carefully wrapped?

FIGURE 3

INTRAVENOUS INFUSION TRAY USED IN THE MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS.

1. Flexible collodion
2. Iodin
3. Alcohol 70 per cent
4. Novocain 1 per cent
5. 3 sterile towels
6. 2 sterile sponges
7. Kidney basin
8. Test tube with intravenous needles
9. Adhesive
10. Flask of solution
11. Sterile towel with three-way stopcock with tubing attached to:
    50 cc. syringe
    Intravenous needle
    Flask

When the tray system is in use, trays on which to assemble equipment may be any one of several different kinds. An oblong enamelware pan about three inches deep is kinder to bottles and bundles than is an ordinary tray. A basket has the further advantage of having a handle by which it can be carried. Occasionally someone works out an entirely new idea which, in her situation, is just a little better than anything that can be bought, and which, by being made at home, extends the budget considerably. The trays shown in Figures 4 and 5 are examples of this. They were made by the hospital engineer from 24 gauge steel and those who use them find that while the compartments are shallow enough to allow the labels to be seen, they are deep enough to prevent the bottles from tipping; everything is visible and accessible; the handles are rigid so the basket cannot tip when it is carried; and although made of steel the lumbar puncture basket weighs only three pounds with equipment, and the other just six.

The study of equipment is extremely interesting and has a very definite bearing on nursing methods. Sometimes procedures seem to become more intricate and to require more

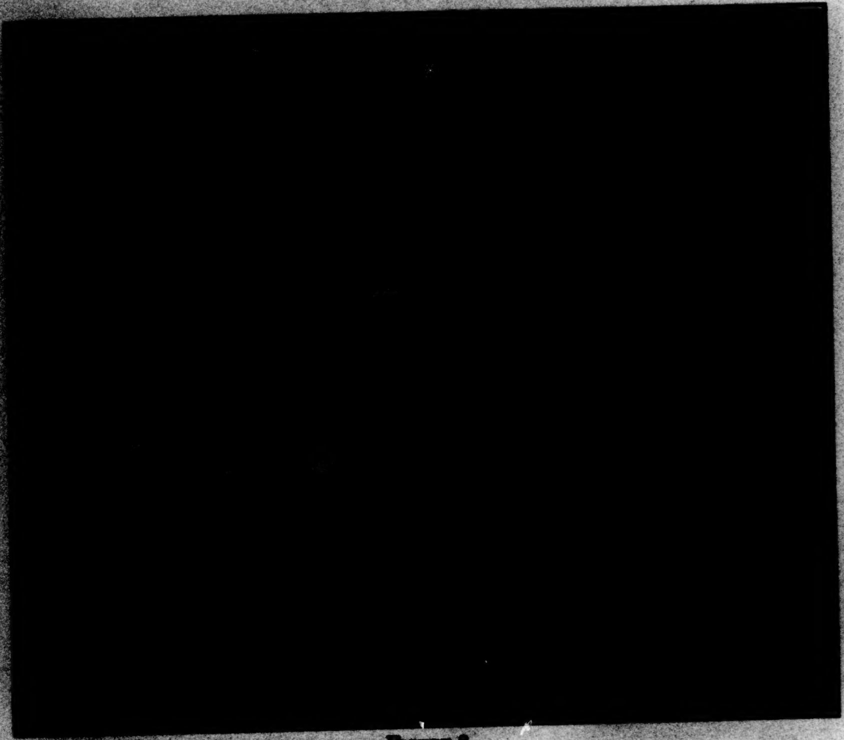


FIGURE 8

INTRAVENOUS INFUSION TRAY USED AT THE SYDENHAM HOSPITAL, NEW YORK CITY

1 Stanley unbreakable bottle
1 infusion thermometer
1 glass connector
4 feet of rubber tubing (stethoscope)
1 metal stopcock, two-way
2 metal adaptors, hose end and to fit Luer needles
2 glass adaptors
1 cannula
2 Luer needles, 19 gauge, 2", in test tubes
1 Murphy regulator
1 screw compressor
1 small drum for sterile sponges
1 white enamel jar, 4 oz., for waste
3 round glass-stoppered bottles, 2 oz., for alcohol 70 per cent, iodin, and collodion
1 test tube to hold applicators
1 glass rod for assorted sizes adhesive
1 package sterile towels
1 package sterile gloves
1 rubber tourniquet
1 simple set instruments
1 scalpel
1 tube catgut, No. 0
1 small white enamel box containing silk
3 curved skin needles
1 straight skin needle
1 white enamel container for test tubes

(Size of tray, 20 by 11½ by 3)

pieces of equipment because we are interested in perfecting technic even beyond the necessary degree. On the other hand, some of us go on improvising even after the need for it has passed. We may like devising something out of nothing, or it may be necessary when a new treatment is being developed. But frequently when such a treatment has become established it would be possible to have the proper things if the need for

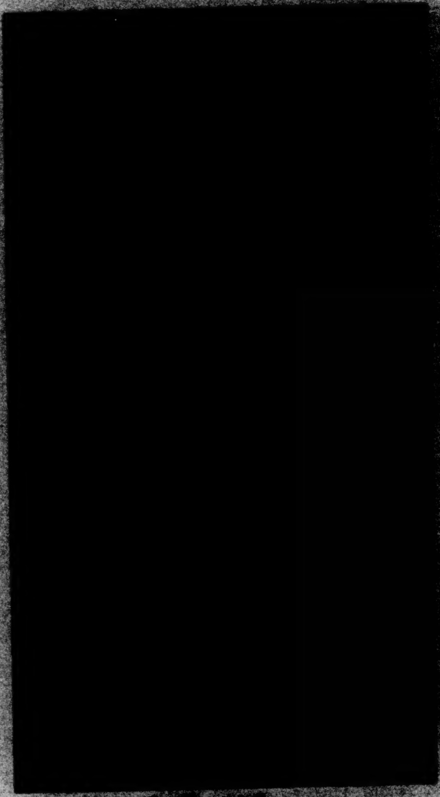


FIGURE 9

FLASK OF PRESCRIBED SOLUTION INVERTED AND HUNG ON IRRIGATOR STAND AS USED IN THE ST. ALEXIS' HOSPITAL, CLEVELAND, OHIO

them were brought to the attention of the purchasing department. The nice balance between too much and not enough can only be determined after analyzing the principles involved in a given treatment and applying to the method chosen the standards: safety, therapeutic effect, economy of time, energy, and materials, comfort and happiness, simplicity and adaptability, and finish.

The trays illustrated are not shown, with any idea of proving which is "best." However they are suggestive and they do make us ask questions, and, since the *Journal* travels far and wide, it seems a good medium for an interchange of ideas on the subject. It is hoped that other nurses will be moved to send in their ideas, with photographs.

Iodine Research Program

SINCE January, [illegible], Mellon Institute of Industrial Research, Pittsburgh, has had in operation a Multiple Industrial Fellowship founded for the purpose of investigating the properties and uses of iodine. All results of the Fellowship studies will be published.

Recently, through an additional appropriation from the Fellowship donor, Mellon Institute, acting for the Iodine Fellowship, has made arrangements for the study of certain iodine problems in other institutions that have special facilities for such types of work. In October, [illegible], a scholarship was founded at the Philadelphia College of Pharmacy and Science which will have for its aim a broad investigation of vehicles and solvents for iodine, especially for external use in medicine. A large number of new organic chemicals will be studied as solvents with the object of evolving, if possible, a more satisfactory preparation than the alcohol tincture now in use.

Another phase of the research program includes a grant made in September to the Pennsylvania State College for a comprehensive investigation of the nutritional place and value of iodine in the feeding of live stock. Despite the large amount of work which has been done on the rôle of iodine in metabolism, especially with reference to the thyroid, very little is known regarding the specific dietetic aspects of this element, particularly in the lower animals. The findings of this research also will be made available to the public.

Mellon Institute is giving consideration to the founding of a research scholarship in a medical school for the purpose of aiding in the solution of incompletely answered questions respecting the utility of iodine in internal medicine. A number of pharmacologists are aiding the Institute in determining the program for such pharmacodynamic inquiry.

Venereal Diseases

Part II — Gonorrhea

MARION CRAIG POTTER, M.D.

GONORRHEA is the most common of the communicable diseases and from an economic and humanitarian aspect the most serious in its effects. It is a formidable rival of syphilis and at least six times as prevalent. The specific organism, the gonococcus, was isolated by Neisser a half century ago. The seriousness of the disease has not been realized by the laity, and through the secretiveness of patients it has either been untreated or the treatment has fallen largely into the hands of incompetent or unscrupulous persons. It is appalling that a disease so detrimental to the health of women has been kept under cover so long. Through this conspiracy of silence, not having proper medical care, infected wives have suffered the greatest injustice. It is marvelous with what high courage many women have met the trouble when they have known and have tried not only to cure themselves but to eradicate the disease in the family.

Gonorrhea is due to a microscopic organism, the gonococcus of Neisser. There is, at the time of the invasion of the disease, some elevation of temperature and other symptoms of acute infection. It is characterised by local manifestations involving the mucous membranes of the urogenital system, but like all diseases of bacterial origin, there may be constitutional infection through the bloodstream. The gonococcus, unlike the treponema pallidum of syphilis, does not infect the skin nor require an abraded surface in order to develop. It attacks the healthy mucous membrane of the urethra. The incubation period is short; within five days the disease is thoroughly established with profuse purulent discharge which is very irritating and contagious.

Finding the gonococcus verifies the diagnosis. If there is a great deal of pus it may be difficult to isolate the organism, but if the history of the case and the clinical symptoms indicate gonorrhea, specific treatment should be given. In acute cases, if treated immediately and persistently, it may be cured in six weeks. It is considered that the virulence of the gonococcus disappears in six months and rarely persists for more than two years, although there may be a resultant discharge and chronic leucorrhea that is not infectious but rebellious to treatment. The organisms have a great tendency to become dormant and may be harbored in the folds of the mucous membrane, making them difficult to reach and destroy. In cases that seem cured, they may unexpectedly become active and contagious, and an innocent bride or newly-wed husband be a victim. Bacteriological tests are the only means to use to be certain of a cure.

On account of the difference in the anatomy of the generative organs of the two sexes, there is a great variation in the pathology of gonorrhea in men and women; in fact, these variations may appear almost like different diseases.

In men, the organism spreads throughout the mucous membrane, causing urethritis, and in its upward course it may affect the bladder, ureters, and kidneys, causing pyelitis. Extension of the disease from the urethra results in inflammation of the adjoining ducts and in prostatitis. The inflammation frequently follows from the vas deferens to the epididymus,

with resulting epididymitis which, if bilateral, may cause sterility. The urethritis often ends in a stricture. In men, gonorrhea is seldom a fatal disease, but is a drag in life, uncertain in regard to cure, and a cause of impotency.

In women, serious and distressing complications occur; the most dangerous and destructive are those involving the generative system. The ravages due to the gonococcus often lead to operations that deprive the patient of motherhood and often of health and life. Sixty percent of all pelvic operations in women are said to be the result of gonorrhea. After infection the organism rapidly multiplies on the mucous membrane of the urethra, causing urethritis and cystitis, with dysuria and tenesmus of the bladder and great discomfort. A vulvovaginitis quickly develops, the parts becoming swollen and tender, and occasionally abscesses occur in Bartholin's glands or the ducts of Skene.

There is usually an early infection of the cervix, or neck of the uterus. The symptoms may be slight and self-limiting or they may respond quickly to treatment, but often the disease is refractory and chronic cervicitis results with persistent mucopurulent leucorrhea. In many cases the infection travels upward through the uterus into the fallopian tubes, causing salpingitis and pus tubes with localised peritonitis. Salpingitis usually develops about the third or fourth week of the disease and is ushered in by chills, fever, pain, tenderness, and swelling, with profuse exudate in the pelvis, causing fixation of the uterus and adnexa. The condition is always bilateral. The leucocyte count is high. In fulminating cases, fatal peritonitis may result.

In salpingitis, although resolution may occur spontaneously, the exudate absorb, and the tubes heal without operation, chronic adhesions of the tubes and ovaries to adjoining structures may be left, causing soreness in the pelvis, and backache, painful and irregular menstruation, and semi-invalidism. Strictures in the fallopian tubes are apt to occur through contraction of the scar tissue left by the inflammatory process and the tubes become stenosed, interfering with impregnation. Sterility is a common result in both sexes.

Gonorrhea, being of pyogenic origin, may cause septicemia, resulting in endocarditis, phlebitis, arthritis, or ophthalmia; all due to metastatic infection. Gonorrheal ophthalmia differs from gonorrheal conjunctivitis, which is a local condition due to the growth of the organism on the conjunctiva from direct contact, and is swift and direful in its course. Conjunctivitis is often acquired accidentally through carelessness in treating patients, or by patients themselves, or by the child at birth from the vaginal discharge of the mother. In babies it is known as ophthalmia neonatorum, which develops within forty-eight hours with a profuse discharge from the eyes, and immediate treatment is imperative to save the sight. At present it is more controllable than formerly. Preparations of silver were known to help the infected eyes, but to Credé of Vienna is due the credit of instituting the practice of instilling the drops into the eyes immediately at birth before the organism has had a chance to multiply. The drops are now a public health requirement for *every* newborn baby for gonorrhea is no respecter of persons. Twenty percent of blindness is said to be due to gonorrheal infections. Regulation 13 of the Sanitary Code previously quoted, reads:

It shall be the duty of the attending physician, midwife, nurse, or other person in at-

tendance on a confinement, to drop into both eyes of the infant immediately upon delivery, a one per cent solution of nitrate of silver, or some other agent equally efficient in preventing ophthalmia neonatorum.

Isolation shall be maintained in cases of ophthalmia neonatorum until two successive specimens of the discharge from each eye, taken at intervals of not less than 48 hours, shall have been found free of gonococci in an approved laboratory.

Gonorrhea is not congenital but children are very susceptible to the infection and may acquire it from towels, bedding, clothing and in many other ways, including assault. In the wards of children's hopitals there are a surprising number of cases with a persistent vaginal discharge due to the gonococcus. In some hospitals children are not allowed to enter without a vaginal smear having been taken to detect the disease, it is so contagious once it has entered the wards. The intact hymen in children seems to obstruct invasion into the deeper structures, to some extent, and vulvitis with urethritis are the most prominent symptoms. However, "It may be followed by adhesion of the labia, occlusion of the hymen, diseased tubes and deformed uteri." We may find, as the disease is better understood, that much ill health among women has been caused by the innocent contagion of childhood.

Lymph nodes are common in all venereal diseases and are called buboes; although they may be due to other ailments, they should always attract attention to the possibility of venereal infection.

Warty vegetations having a cauliflower appearance, condylomata acuminata, or venereal warts, may occur over the perineum. Keeping the parts dry and antiseptic helps them to disappear. If persistent, a skin-dose x-ray treatment is effective in curing them.

The treatment of acute gonorrhea consists in caring for the main complication, the urethritis, cervicitis and proctitis. Rest is of prime importance; and postural drainage, such as Fowler's position, reducing the temperature, cleanliness, anodynes, forcing quantities of water and urinary antiseptics, as acriflavine, are indicated. If antiseptic douches are used, force should be avoided, the douche bag being only slightly elevated. Preparations of silver destory the gonococcus, and an application of a ten per cent silver nitrate solution or a twenty per cent solution of mercurochrome to the cervical canal will help arrest the disease.

Swabbing the vagina with a fifteen per cent solution of argyrol and instilling the same into the urethra destroys the gonococci. In cases of infection of the rectum, which occurs in about sixty-five per cent of women patients, an ounce of the solution may be injected into the rectum and ejected soon.

In treating the bladder, the urethra should be swabbed with the argyrol solution. A small catheter attached by rubber tubing to a funnel should be dipped in the argyrol solution before using, and residual urine withdrawn. After catheterisation, an ounce of the argyrol should be left in the bladder and the catheter removed, the patient voiding immediately. Thus the argyrol acts on the urethritis as well as on the cystitis. The argyrol, being antiseptic and mildly sedative, is one of the best preparations of silver for this purpose and should be used freely in acute cases, but not indefinitely. The possibility of argyria should always be kept in mind.

If an irritable caruncle is present, which is always exquisitely sensitive, it should be ablated by fulguration.

The cervix of the uterus is a stronghold in which the gonococci congregate and colonise. It is important to destroy these nests of disease. In prolonged cases, a radical treatment of the cervix with the electric cautery may be necessary.

When an extension of the disease takes place from the cervix through the uterus to the tubes, causing salpingitis, there is an exacerbation of all symptoms. Rest and time are great elements of cure in this condition. It may take weeks or months. Ice packs may be used over the uterus and tubes, or hot water bags on the abdomen if they give more relief. Ultraviolet ray, infra-red therapeutic light, diathermy, rest in bed, pelvic and sexual rest, are all indicated. Also hot antiseptic douches and depleting measures, such as icthyol or boroglycerid tampons. Menstruation seems to relight and activate the trouble, and relapses are common, with pain and soreness through the pelvis and abdomen.

Antigonococcus serums and Neisser vaccines have a curative effect on the pelvic inflammatory condition. They are also helpful when there is general systemic infection. They should be continued only about two weeks. They build up resistance and help the patient to establish her own immunity to the gonococci.

Surgeons are much more conservative than formerly in regard to operations. If an operation is necessary, the leucocyte count should not be above 11,000 for two weeks before operation, and the polymorphonuclear count should be below seventy-five per cent.

The following is from a recent article by Dr. Polak:

> It is now an accepted principle that there is no operative treatment for acute salpingitis, for unless a local abscess forms in the culdesac which admits of vaginal draining, the management of this type of infection is essentially medical. Only the "cooled case" should be operated upon, and then operation is not done to cure the infection but for the relief of symptoms traceable to the resulting pathology. Rest and time usually effect a symptomatic cure.

In treatment of the inflammation of the tubes and ovaries and the exudate and adhesions following acute infection, he advises in the course of two or three months the use of small doses of x-ray, non-sterilising, but sufficient to cause an amenorrhea which lasts for several months. This may be repeated if necessary. Skene's tubules often remain infective foci and should be destroyed before the x-ray treatment. He has found that under x-ray, like the exudate from tuberculosis, the exudate from gonorrhea melts away.

He further states:

> X-ray treatment has a definite curative action and without it premenstrual, pelvic and abdominal soreness may keep up until the menopause, when all subjective symptoms seem to disappear.
>
> I believe by the employment of this simple means of treatment we may shorten the period of infection in tubal infections, conserve the adnexal function, and save many women from mutilating operations.

X-ray is a boon to woman and a great addition to the armamentarium of the gynecologist.

In chronic conditions resulting from the disease, obstruction of the sealed fallopian tubes can be demonstrated by inflating them with a Rubin's test. If an obstruction is found, lipiodol solution may be injected into the uterus and tubes and an x-ray picture taken. The position of the strictures will be shown and it can be demonstrated whether it is a suitable case for operation to relieve the stenosis and the resulting sterility.

Before treatment a complete physical examination in regard to the

general health of the patient should be made and any foci of infection, such as teeth or tonsils, or any constitutional defect, corrected.

Eternal vigilance is the answer to the question: "What precautions should be taken by an attendant in order to prevent infection?" Abrasions on the hand should be protected and healed; rubber gloves and finger cots are always useful. Fortunately, unlike the germs of tuberculosis, the organisms of venereal diseases become sluggish outside of their environment and soon lose their virulence, living only a few hours when dried or exposed to air. Washing the hands thoroughly with soap and water destroys them and is a great factor for safety.

In regard to prevention, *continence* is the whole solution. "Sex expression" means sex problems, disease, suicide, celibacy for fear of results, and divorce; and we may add homicide, for many women have been slain from the infection of a venereal disease. What a terrible price to pay for knowledge! Although there is nothing in the divorce laws mentioning venereal diseases, it should be a criminal offense for anyone knowingly to infect another. Invading, as they do, the territory of youth, they are a challenge to parents to give their children proper and scientific instruction in regard to them. The New York State marriage license is enlightening, a splendid contact for parent and child, and should be intelligently studied:

> I have not to my knowledge been infected with any venereal disease, or if I have been so infected within five years, I have had a laboratory test within that period which shows that I am now free from any such infection.

A great impetus was given to combat venereal diseases at the time of the World War, when it was discovered that the percentage of cases among the enlisted and drafted men from the civilian population was greater than in the Army and Navy. The government immediately provided for the establishment of the Division of Venereal Diseases in the Bureau of the Public Health Service, with coöperating service in the State Department of Public Health and, in order to prevent the circumstances that develop temptation, vigorous steps were taken to protect the men from alcohol and immorality, which seem to go hand in hand. "Constructive work along social and hygienic lines, both on the educational side and that of treatment, was developed. Most of the men had been entirely ignorant of the dangers of venereal diseases, for they had never been informed by home instruction."

A sound plan for venereal disease control—according to Dr. Pfeiffer—would embody those measures which made up the so-called "American Plan of Venereal Disease Control" during the recent war, and which essentially consists of:

1. The establishment of treatment centers throughout the country, making free treatment available for all indigent cases.
2. Repressive measures against prostitution and promiscuous intercourse.
3. Educational measures to acquaint parents and adolescents with facts regarding these diseases and the necessity for thorough and scientific treatment.

Interest in health, private as well as public, must rouse in all nurses the desire both to inform themselves on the subject and to take their places in such programs.

"Health depends on character as much as on intelligence; knowing what is good for us will be of little avail unless we have the will power to do it. Therefore too great emphasis cannot be given the idea that a course of health education is not intended for the mere teaching of rules but to create and fix practice."

The Nurse and the Public

III—Nursing and Newspapers

VIRGINIA McCORMICK

THE public, as the purchaser of nursing, has the right to know such facts about nursing as it needs for its own protection. A realisation of this fact leads us to ask how we can reach the public most directly and most effectively. And at once we think of those newly-inked sheets lying on our doorstep every morning, inviting us to scan the happenings of our swift-moving times—the newspaper.

But nursing and newspapers, have they anything in common? What stories has nursing to offer that can find a legitimate place in the daily press? More than one nurse, remembering how her carefully composed report of an annual meeting was rewritten before its appearance in the press, and more than one nurse, recalling an ineffectual attempt to have published a notice of a district meeting, will assert at this point that newspapers do not want nursing news, that they will not give space to nursing, or that, if they do, the stories will be changed almost beyond recognition.

Such asservations, of course, have their foundation in unsatisfactory experiences with the press. But the chances are that there is a sound reason for every omitted notice or altered piece of copy.

Newspapers Exist To Issue News

NURSING is news if it interests the public. Newspapers will publish news on almost every known topic. Certain editorial policies govern the selection of subjects, but it is safe to assert that the large majority of papers in the United States will publish gladly facts and developments in nursing *if these make a popular appeal.* Newspapers are not apt to publish what is of interest to only a small group of readers. Generally speaking they will not publish stories that were news three days ago or last week. But stories on current happenings of general interest are almost sure to find a place in the columns of the well organised newspaper.

Newspapers exist to disseminate news. They welcome items of interest. If, then, nursing is news, the failure on the part of some nurses to get their stories into the papers may be due in part or entirely to the nurse. She may not have recognised the elements of news in her story. She may not have presented her facts in usable form. Or she may have violated some basic editorial ruling as to time or accuracy.

Three Points to Remember

IF you are the nurse leader on whom devolves the responsibility of telling some stories of nursing to the public, you need to

1. Recognise the news elements in your nursing happenings.
2. Present the story and place it so that it will be used to greatest advantage.
3. Learn and practice the simple editorial principles upon which newspapers function.

News Elements

WHAT is news? How can you tell what the newspapers will take? The formula is a simple one: *Whatever is of interest to the public in nursing, is nursing news.* Whatever happens in the district or state association, in the hospital training school, or public health group that has a direct

bearing on the public, or that affects the possible patient, that is an item for the newspapers. What you as a nurse consider of importance from the professional angle has nothing to do with the value of that information to the papers. The only elements of news in nursing are those that are of public interest.

The housewife, reading her evening paper after the children have been put to bed, does not care a "continental" that the district association met the preceding evening. Neither does the city editor. But the city editor will give a half column to the story that at the district meeting, March 1, the nurses made plans to meet the nursing needs of the city by enlarging the scope of the official registry. The housewife, having experienced the expenses of illness, will read that story because it directly affects her.

View from Reader's Standpoint

IF there is any doubt in your mind as to whether there is news in an occurrence in nursing, test it by putting yourself in the place of the *average reader*. Is it a story that the bank clerk will read as he goes home on the street car? Will it be read by the lawyer and the butcher and the mayor's wife because it deals with something they all understand or are interested in?

Read your newspaper tonight and note how each story is presented in a way that is calculated to interest *you*.

It may be the story is real news; that is, the recounting of some new happening or development in nursing. It may be of interest because of its "human" elements, because it describes a brave, or a humorous, or a pathetic incident and, therefore, is read because it evokes an emotional response on the part of the reader.

Such a story is that headed

Nurses Carry Aid to Coal Strikers' Homes

A SUB-HEAD states, "Nurses Face Peril Daily," while another reads, "Tired Out but Never Done." The text of this paragraph begins:

> Out to the homes, over roads where pack horses are necessary to transport food and supplies, back to the school center to report a case where supplies must be carried, into the miserably small shacks which dot the hillside, these girls go; into famine and disease fearlessly. Is it any wonder that when night comes they are fatigued?

This story ran to almost a column in length. It was copied from the city newspaper into smaller papers, giving it wide distribution. People read it because they liked to read of personal bravery. They like to think they would do the same thing in similar circumstances. And do you know where the story came from? From a report, a presumably dry and stupid report, too full of figures to permit a glimpse of personal deeds beneath. But, we will wager, it was not a report mailed in to the newspaper with no comment, but one personally interpreted by someone, either to the city editor, or to a competent reporter, quick to recognize the interest in those nurses that the newspaper readers would feel.

Local Interest

EVENTS in nursing must be of interest to the public. But more than that, they must be of interest to that particular segment of the public reached by that newspaper in which a story is to appear.

There are two types of material that go into the making of public information on nurse matters. There are the stories that can be placed in almost any newspaper because they appeal to a large audience or because they are in terms of the reader's experience and

therefore of interest. And there are the stories that, to be of interest, must have a direct local application.

In illustrating the latter type, we call to mind vividly an occurrence two years ago. Before the Louisville biennial convention, a nurse in a rather large city went to the trouble of collecting photographs of all the American Nurses' Association officers. These she sent to a local newspaper with a brief notice of the approaching convention. Her chagrin was great when the story was not used and the pictures were returned to her unpublished. She will assure you that that paper will "*not* take stories about nursing, and there's *no* use trying to get them in."

What happened? Preconvention stories about the biennial were being sent regularly to that paper, among many others, from American Nurses' Association Headquarters whence national convention publicity is issued. These stories were designed to be of local interest because the material used was of direct import to the readers. They were preferred, of course, to the local nurse's unelaborated notice of a coming meeting in a distant city. As for the pictures, they were of nurses scattered here and there throughout the country. Had the group of photographs been of local nurse leaders sent as delegates to the convention, and did the newspaper's policy regarding the use of pictures permit, it is safe to assert that that paper would have taken them gladly, with probably those of a national leader or two besides.

In planning the placing of a story you have to consider: (1) Are you the person to release this story, or will it be more effective if it comes from another group with added information to give it wider interest? (2) Whom do you want to reach with this story and through what newspapers will you contact this group?

Strategic Placing

LET us take the second question first. If your story is one about the growth of university schools, it will not find readers among the tabloid devotees. Such a story must be placed in that conservative organ read by the educated group. But if, in writing your story about university schools, or giving it to a reporter, you stress the fact that this means better nursing care for the patient, then do not hesitate to send it to as many papers as you think the story warrants. In order to avoid duplication, send a copy of the story to your state publicity chairman or the person in charge of state association publicity, with word of where you have sent it. Or, if the story is, in your estimation, of statewide interest and you are not in touch with the newspapers of the state, send the material to the state chairman with a request that she distribute it.

Coöperation vs. Duplication

THE chances of duplication of effort are illustrated by the nurse who issued the biennial publicity which already was being handled from National Headquarters. The national office has policies and a program of public information. In some states, there now are publicity chairmen working along specific lines, to educate the public in the need for new legislation, to develop constructive programs in the districts with adequate publicity in the newspapers so that the work of the local nurses may be continuously before the public, or to draw more closely the various nursing interests in the state with a view to a coördinated publicity program. Some district and alumnae groups also, we

are told, are beginning to carry on systematic publicity.

Coördination

COÖRDINATION of all these elements, through regular contact, is necessary if nursing information for the public is to be effective. District and state chairmen need to work more closely together and they, in turn, need closer contact with the national office. For instance, the story of the biennial convention could have been strengthened in interest to a very real degree, had the nurse who undertook to issue national news herself first gotten in touch with American Nurses' Association Headquarters. Duplication in effort would have been eliminated and, better than that, the nurse would have been asked to add such local facts about delegates, number of local nurses going to the convention, and the like, as would have added greatly to local interest in the national release.

Distribution

NEWS receives distribution in ratio to the breadth of its interest. The election of the President of the United States is headlined in every paper in the country, and noted in the press of the world. The governor's election may receive brief mention in the newspapers of neighboring states, but is featured only in his own state. Unless a newly elected mayor is for some reason a conspicuous figure, his election will be noteworthy only in his immediate vicinity.

But very often there are local aspects to a story which can be used to advantage in a national release, and others of a story which may seem only local in character, can have a much wider distribution because it is a problem or happening evoking wide interest.

For instance, a three-page mimeographed Bulletin is issued monthly from American Nurses' Association Headquarters. Last year this was sent chiefly to nursing publications and to state headquarters. It was widely copied in professional publications, but there its usefulness ended. Beginning in February, this Bulletin is sent to every accredited school in the country and to all official registries, as well as to the former list. About half the brief items it contains are on technical nurse subjects of no public interest. Any one of the remainder might be sent to a local newspaper with some local emphasis to give it the necessary interest.

The story carried as a lead in the January Bulletin, of how two California hospitals had instituted the eight-hour day, might have been given to the press of that state by the person responsible for publicity in the alumnae associations of the hospitals, by the hospital authorities, or by the district association. By reason of which you will note the absolute need for coördination of resources, the wide possibility of duplication, and the excellent chance for an interesting story. And note also, that this story would not be that the nurses now work only eight hours, or that nurses find the eight-hour day satisfactory, but that eight-hour duty means *better nursing care for the patient*, in the estimation of the group issuing the story.

Individual Reticence

EVERY organization, presumably, has members who crave publicity either for themselves or for their immediate group. Perhaps the point about nursing publicity that commends itself more than all others to the profession, is the fact that there is no room for personal exploitation but that the individual remains in the

background as consistently as in her daily work. It is the work that counts in the story also because that is what is of importance to the possible patient.

There is an opportunity for confusion in this regard. The promotion of the individual certainly has no place in nursing publicity. But often the greatest value can be obtained from a story by presenting it in interview form, centering it on the individual. Here again, however, the nurse is subservient to what she says.

Thus, nursing is vitally interested today in the economic problems of the private duty nurse and the equally difficult high cost of sickness. Last autumn when the Headquarters Director of the American Nurses' Association made a field trip to the West, advance copy was sent the newspapers of the cities she was to visit. This was prepared in interview form, but it was not of Miss Geister herself that the story dealt, but of Miss Geister telling of the active concern of the American Nurses' Association in these problems.

Fixed Responsibility

IN issuing this story, as all others, there must be one person responsible. Information can be issued best by one person in every group who is directly responsible for studying the work of that group with public information in view, the superintendent of nurses, the state executive secretary, or the chairman of the district publicity committee.

Another advantage in thus fixing the responsibility on one person is that it is highly desirable to give your stories always to the same person on the newspaper. It is almost always necessary to explain some point for elaboration, and by going to the same reporter on each occasion it is possible for him to acquire before long a superficial fund of information about nursing. He will use terms correctly and will begin to look for nursing stories every now and then. In time, he may even take the initiative and get in touch with you to see if there is a nursing story he can use. And, perhaps most important of all, if the reporter or city editor knows exactly where he can turn for accurate nursing information, he will ask your verification of other stories about nursing as they come in to the paper.

The advantage of the personal contact is not to be underestimated. It is much better to go with your story to a paper than to mail it in, unless it be only a notice of an imminent meeting. Often a story which would be discarded as of little interest takes new shape after the experienced reporter has questioned you about it. By far the best plan in releasing any story more elaborate than a simple notice is not to write it yourself but to fortify yourself with accurate written data and, so equipped, tell the story to the reporter assigned to you. He knows the editorial rules and policies of his newspaper as you cannot know them and, being a trained writer, he will give the story its fullest possible news value.

Newspaper Rules

THERE are a few simple rules to which always and unfailingly you must adhere. The first regards time; the second, accuracy. Newspapers function on a strict time schedule. Yet many, many persons do not see what difference a few minutes make. I once covered clubs and similar organizations for an evening newspaper. The page closed at ten in the morning. Our busiest time at the telephones was from 9:55 to 10:20 which, except for the first five minutes, was spent in

explaining, with what patience we could muster, that that Ladies' Aid notice would have to wait until next day. Yes, we knew it was only 10:05, but the page closed at ten o'clock.

That almost forgotten nurse at the beginning of this story who wondered why her district notice did not appear, perhaps, phoned it in at 10:10. Maybe, however, we are misjudging her. Perhaps she typed the notice and mailed it the night before and perhaps the notice read

District No. 2 will meet Tuesday evening. Miss Jones will speak on dietetics and Miss Williams and Miss Smith will be hostesses.

Accuracy! It has always seemed a bit odd that nurses who must be so precise and so unswervingly accurate in their professional practice, can be so casual in such matters as writing a notice. Who is Miss Williams? Which Miss Smith? Where is the meeting? Which Tuesday? District of what? In other words, there are a half dozen reasons why the notice was not published.

Newspapers have varying rules about the publishing of names, explicit dates, and the like. But it is a safe rule and true to good newspaper usage that no name except the full correct name identifies the person; that dates must be given accurately; that titles must be correct.

Then there is the matter of the week-end papers, the Saturday evening or Sunday morning editions which always are made up in advance. If you want the story of your new training school in the Sunday paper, you have to make sure it is received at the paper by Wednesday or Thursday, according to the time of closing. Straight news stories, of course, are received up to the last possible moment. But with stories appearing in any but the news sections the early closing date holds true.

And pictures. Do not take your state president's picture to the paper Monday evening and expect it to appear Tuesday morning unless she has just risked her life to save a patient, or single-handed has extinguished a bomb that threatened her hospital. Pictures take time to make up and those for the week-end editions sometimes have to be in as early as the preceding Monday.

Above all, in sending the story of a happening, do so just as soon as it has occurred. News is of value only when it is new and the group that sends in on Saturday a story of a meeting held the previous Tuesday might have saved itself the trouble. The event of an evening should be read at the breakfast table next morning or, at the latest, at tea time that afternoon.

All this may appear trite to you, yet the offenders in all these simple matters are legion. To secure the coöperation of the newspaper, *you must at the very least conform to their rules and their policies.*

Continuity of Program

We have mentioned at intervals during the story the need for a continuous program of public information. Perhaps that suggestion may seem premature when nurses are only beginning to realize the need for telling their story to the public and are not, in the majority of instances, equipped to carry out a publicity program.

To some degree this is so. And it is granted that all newspaper stories must be upon an opportunist basis, taking advantage of happenings, achievements, and personal accomplishments to tell a more complete story. But if there is one particular objective or direction in this public information, if it is issued by a person or group knowing this objective, if contacts are maintained with the

publicity chairman or committees of similar nurse groups carrying out the local, district, state, and national work of informing the public on nursing subjects, then it is quite safe to prophesy that the time is not far distant when the possible patient will be drawn into closer coöperation with nursing because he is aware of nursing problems and nursing aims as they directly affect him.

Summary

1. Nursing is news if it interests the public.
2. To place stories in newspapers to best advantage, analyze first the type of story, the type of person who will be interested in the story, and the breadth of that interest, whether of local or broader scope. Then select the paper that will meet your needs.
3. Have a fixed responsibility for public information, with one person directly in charge of releases.
4. Coördinate work and coöperate with other nurse groups, giving them the stories that they can place more advantageously than you.
5. Make direct contact with newspapers, if possible, always with the same individual.
6. Do not try to write the story, unless it is a brief notice. Write the facts clearly and let the reporter do the rest.
7. Abide by the basic editorial rules regarding closing dates, "dead line," accuracy, etc.
8. As much as possible, let all stories conform to a specific objective in public information or to a continuous program.

[This article is designed particularly to reach the groups and their individual leaders responsible for public information, such as executive secretaries, publicity chairmen, state and district officers, hospital executives, etc.—EDITOR.]

Welfare Nursing in Factoryville

EVERDEAN HARMELING JOHNSON, R.N.

FACTORYVILLE, with its 22,000 population of mill and shop employees, needed welfare nursing. Accordingly, they hired a graduate nurse to undertake the task of dealing with both the foreign and the native American citizens who make up the population. The gigantic health problems which were theirs invariably included financial or domestic troubles as well. Each family had its own so-called "background" and, in order to carry out a definite and reconstructive program in that family, it was necessary for the nurse to acquaint herself with that background. Here is a case in point:

In isolated sections of the southern mountains, where primitive rural conditions still exist, families are known to their locality or community for at least three generations back. They may keep moving from one county to another but, nevertheless, they *are known* to their neighbors, who are largely kinfolk, who can judge most accurately concerning the help needed by that family. Two mountain workers were asked to ride inland a considerable distance to Redbird Creek, where lived a family which needed help desperately. When the workers arrived at the log cabin, they noticed several things that made this home differ widely from other mountain homes. There were no men about the premises to come forward and assist them in dismounting and caring for their horses, although this is a universal friendly act in the mountains and is never omitted. They found, on entering, that the mother was sullen and openly mistreated the little children playing about the fireplace, although in this locality children are especially petted. A sick girl of

seventeen years, very worn and emaciated, had hair of a suspicious henna shade. She wore a flimsy party dress and extremely high-heeled pumps, with flashy ornaments as buckles (articles unheard of in mountain regions). There were cornflakes and soda crackers on the crude plank table, both foods were plainly "brought on," as they say in the hills, while the children were munching candy that could not have been purchased at any "storhaus" in the mountains. Plainly, this case needed investigation and, painstakingly, the workers were able to gain the information necessary to their being of real service.

The family had originally lived in the mountains, but kinfolk had persuaded the father that work and good pay were to be had for the asking in Factoryville. They concluded to move to the city, where the father and sons went to work in the mill while the mother kept roomers and boarders, hoping to swell the monthly pay check. She, however, was unused to the strange city life and soon fell in with bad company, and eventually led her daughter astray. When knowledge that she had disgraced him came to the husband's ears, he, in stern mountain fashion, left her, taking the two boys with him.

On finding later that her daughter had developed tuberculosis, the mother made a drastic attempt to recover the girl's health by returning to the mountains, also taking back with her three little children whose working parents, not knowing the danger, were induced to board their children in the mountains, innocently believing that those surroundings would be better for them.

On returning, the mother found that her mountain neighbors had ostracized her, for news travels quickly there, in spite of isolation. However, they were unwilling that she should be without aid, so they called the social center hospital fifty miles distant, asking that "these good wimin come ter holpen har a mite." This accounted for the fact that no host nor neighbor helped the workers dismount from their horses; in fact, no one had come to extend any cordialities whatever, although cabins were usually crowded with friends and curious ones awaiting an expected visit. It also accounted for the sick girl's attire and the fact that "brought on" food was used instead of mountain fare. The woman who boarded the children for "keep," as she expressed it, was not at all affectionate toward them, most likely because of the bitterness in her own life.

The combined efforts of the mountain workers in their sphere and the welfare nurse in Factoryville, where the family sojourned, brought real aid to the group, but not at all in the manner the mother had anticipated. Her daughter was placed in a sanitarium where, because of her advanced case, she later died. The little children, who were so cruelly exposed to the "White Plague," were brought back to Factoryville and kept under clinical observation until it was certain that they were not its victims. The nurse visited the father and tried earnestly to effect a reconciliation between husband and wife and, when she failed, placed the mother in good, clean quarters at the local Y. W. C. A., where she was able to work as cook's helper, earning a satisfactory wage.

This mountain family, away from its mountain background, was hard to understand and to handle tactfully, until the welfare nurse knew the facts and literally *saw* that background. Then adjustment could be ventured upon.

A foreign widow, Mrs. Browneweics, the mother of nine children (all under the working age), did not understand the ways of the new world. She was so harassed by tax assessments and back payments, unpaid, on her heavily mortgaged property, that it nearly drove her frantic. Severe illness completed the vicious circle of misfortune. Quite in the depths of despair, for she had received extradition notice also, she called in the welfare nurse. A physician was asked to call at her home and treat her there; her children were given clinical care; the baby readily responded to care in "The Nursery," a suitable children's hospital, and the nurse, after many fruitless attempts, succeeded through legal aid in gaining a cancellation of the widow's property debt by releasing her ownership of the house and lot deeded to Mr. Browneweics, her deceased husband.

Then a diligent search was made for a flat that would house ten occupants without overcrowding. Coal, rent, groceries and furniture money and moving expenses had to be forthcoming until the poor widow was made eligible for her mother's pension under the state law.

She was puzzled at requirements made by that bureau for taking out citizen's papers, naturalization, etc., and, step by step, the nurse had to prepare the way and explain matters to her. Progress in her case was slow, often at a complete standstill because, invariably, the nurse had to act as tutor to her charge, in order that Mrs. Browneweics might reap the benefit of that wonderful institution, the mother's pension, which she eventually received.

The welfare nurse, however, has often "fallen by the wayside" in trying to establish a change for the better in homes where she was asked to help. Sometimes the case seemed to be hopeless from every angle, and then again only the most drastic measures would bring results in the form of family reconstruction work. Each case required thorough investigation and understanding of the problems, as well as untiring effort in planning for the betterment of living conditions among individuals and families in Factoryville.

This mill city is typical, as factory towns go. Undoubtedly, it had a population very similar in composition to that of other mill towns, and human nature is human nature anywhere you place it. The welfare nurses in Factoryville have a real course in solving the multitudinous problems belonging to factory people and, perhaps, a postgraduate course in receiving better insight into that subtle thing called—human nature.

The International Hygiene Exhibition, Dresden, 1930

FROM May to October, 1930, an exhibit of much interest and on a very grand scale is to be shown in Dresden. This is the International Hygiene Exhibition which will have as its nucleus the Deutsche Hygiene-Museum, an institution founded in 1911, for the purpose of teaching hygiene and health. From this Museum traveling exhibits have been sent out through Germany and into many other European countries and have cleared the way for popular education in hygiene.

A special unit of the 1930 exhibition will be the Hospital Exhibit in which nursing will be included. An interesting feature of this unit is the fact that it will be arranged by committees of all countries which were organized during the International Hospital Congress in Atlantic City last June. The purpose of the whole exhibit of which this one is a part will be to show the need for racial hygiene and will deal with man in relation to his natural needs and environment. The subjects with which individual exhibits will deal will be varied. Judging from the prospectus, the displays will not only be of unusual beauty but of great educational value as well.

A Psychiatric Case Study

ESTHER H. STONE, M.D.

PATRICIA SUMMERLY had been married ten years when she developed her first mental disturbance and sought treatment in a state hospital. Her family had noticed for some time that she presented a complete departure from her usual self. Her usual quiet, self-possessed, matter-of-fact make-up was displaced by a childlike, simple, often foolish, simpering attitude. This symptom group was so puzzling and, manifestly, so new that they were convinced that there was something materially wrong with her mind. During this phase of her illness her personality make-up and general behavior were comparable to those of a child of ten or twelve. She would become coy or playful; would show a slight drawl and lisp in her speech; would hang her head sideways and look up shyly; twist her finger in her mouth, and act typically the half-coy, half-embarrassed child. This complete change in her make-up was said to have been precipitated by an attack of influenza about two months prior to commitment.

Her family and personal history were uneventful. She was twenty-eight years of age, the third born of seven children in a poor laboring family. The father, a wheel-chair invalid for years, was not only paying for his early alcoholic excesses but continued to burden his family by his helpless invalidism and grouchy, irritable disposition. The mother, a nervous, timid, care-worn woman, had for years shouldered the entire burden of providing for her large family and invalid husband.

The patient's personal history was entirely negative. She was a healthy child; suffered no developmental difficulties. Aside from the usual diseases incident to childhood, her predominating health was good. School and social life were normal; she enjoyed the usual play interests. She was bright in her studies, a good mixer, and stood at the head of her class. Always very ambitious, she would work after school hours at anything she could get, to assist in caring for her family. Secret love affairs and disappointments were denied. Though possessed of moderate good looks and favored with the usual attentions of the opposite sex, she never exhibited a tendency to numerous flirtations, nor was she guilty of doubtful relations with boys. Persistent delving into her history by questioning her relatives failed to clarify this case or throw any light upon the condition from which she seemed to be suffering.

During the first two days of observation in the hospital she spoke very little, gazed about her confusedly, made a visible effort to orient herself, but showed complete memory loss for present events and those that immediately preceded her coming.

She was disoriented in all spheres, did not recall when she came nor how she got here, did not know how long she had been here, but it seemed long to her. Past memories were well retained, particularly of her remote past. She was conversant with events in her past life, but showed a complete blotting-out of all recent memories. Hallucinatory experiences were not marked except that once in a while she thought she heard her name called. She frequently gazed at herself in the mirror and said that she could not recognize her face. Ideas of persecution were denied.

The outstanding symptom then, on admission, was a period of amnesia in her life which could not be accounted for, and her mood was cheerful in a childlike way and, as has been stated, an interesting factor was the sincerity and naturalness in her attitude. It was not assumed. She did not act the part; she was no poseur. She seemed actually to fit into the part as if born in it. Her speech was coherent when not interfered with by memory loss. She did not converse freely but answered questions when addressed and when she understood them.

The salient facts of the case were: The patient was a young woman of twenty-eight years, with no background of insanity, and no previous mental upset, whose one pronounced symptom was memory loss over a definite period of time. All that we could gather from her relatives was that her illness began with moodiness and fits of abstraction which later developed into a change of personality in which childlike mannerisms predominated.

It was after the patient made a complete recovery that she was enabled to give us the various factors that led to her mental break, resulting in an amnesia that involved her entire married life.

She stated that she was married shortly after she left high school. Her family greatly opposed her marriage to her chosen mate. She later realized that their opposition was amply justified, but it was too late. Her husband was a confirmed drunkard, an idler, and associated with a disreputable crowd. He began to neglect her soon after they were married and to abuse her almost constantly. It was the patient who was obliged to assume the burden of providing for the home, while he spent her earnings in drink and incurred a great many other bills that she was obliged to meet.

His character traits were incomparably bad; he was inordinately selfish and cruel. To hurt her feelings, he would often boast to her of his conquests and familiarities with other women. He was particularly vicious and cruel when drunk. He would provoke her to quarrel, would call her vile names, and often strike her. Of the ten years they were married, he worked only about two years in short snatches. He not only failed to maintain the home, but even refused to contribute to his own support.

His vain and bizarre extravagances drove her to renewed efforts in her work. He wasted her earnings in drink and other excesses. Whenever she buoyed up her courage enough to upbraid him, he would threaten to leave and take the child, who was then five years old. The fear that he might carry out his threat kept her enslaved and subjected to his endless cruelties. The child, apparently, was the only link that kept her tied.

His many studied ways of inflicting anguish kept her constantly under a great deal of nervous tension. Invariably, he would get ugly and pick quarrels when the patient's customers were in the home. Anxious to keep her customers from knowing her domestic difficulties, she would quickly accede to any of his extravagant demands just to get him out of the house.

She had for years suffered his assaults and abuse in silence. He, with the drunkard's usual delusions of infidelity, would accuse her of immoralities and misconduct of which she was never guilty. He often used his delusions as a means for attacking her and starting up quarrels. Throughout the years of suffering that

way she never spoke of it to anyone. She was too proud to go to her own family with her difficulties, since they had opposed her marriage in the first place and were not greatly in sympathy with her. She also voluntarily severed all connection with her former friends, fearing the disclosure of her home life. She had for years denied herself all social contacts and recreation, not only because her work demanded all her time, but actually because of a fear that her wretched domestic difficulties might become known.

Her life continued in this unhappy state until an attack of the "flu" made it necessary for her to take a rest from work. It was while in a weakened and semi-delirious state that she was attacked by her husband, coming home drunk one night. He struck her several times and dragged her out of bed. The attack was so sudden that she was stunned. She could not defend herself. She could not even run away as she had used to do. She sobbed weakly, begged and pleaded, while he continued beating her mercilessly, until her lip was cut and hanging and eyes swollen shut. He struck her down every time she rose from the ground. She tried to escape him, but he succeeded in overtaking her. Her effort at escape seemed to augment his rage. He decided to put an end to her, and told her he was going to kill her. He caught her as she broke away, threw her into the automobile, and drove what seemed to her for hours on a dark and lonely road, beating her almost to insensibility as he drove. Then, lifting her out of the car, he threw her from him with all the force he could muster, but not before he had dangled her body high over a bank, threatening to throw her into the river. In the morning she was found wandering on a deserted road far from home. She did not know her name nor how she got there. Her people were found and she was taken home. She remembered nothing of what had transpired the night before; did not know how she happened to be so far away from home nor that her face was swollen and bleeding. She did not feel any pain. She made the statement that "Things flashed and broke in my head." It is fair to assume that the patient's break from reality occurred at that period.

The events of that night were responsible for the development of the mental blankness that enveloped her for a long time. The period of amnesia involved her entire married life. A whole block of her life, as it were, seemed to have been wiped out, probably because of the unbearable anguish and suffering throughout that period, which culminated in the profound shock of the night of her husband's attack upon her.

The mechanism of forgetting, particularly involving the segment of her married life, is probably protective in nature. The fact that she assumed the mental level of a child undoubtedly proves that she has found some comfort and the possibility of existence at a lower biological level.

Her forgetting included immediate events. When her people called she forgot that they were there. Her husband's visits were forgotten instantly. She could not recall that he was ever there. At first she failed to recognize her relatives; later she began to know them by their voices.

Her description of her husband was quite interesting. She would usually describe a fictitious personality, a Prince Charming, a man of the finest humane attributes who loved her devotedly and sought only her happiness. She described a personality

that she dreamed of and greatly desired. The pictured husband was a symbol of her wishes but not an actuality.

A determining factor in the prognosis was her altered material and financial condition which was reëstablished by the aid of her people. She began to improve quickly as her burdens were lessened. She showed a distinct gain in judgment and intelligence by completely severing all relations with her former husband.

Another important factor in the restorative process was the splendid efficient and able nursing of the patient without which no such progress could have been made. The nurse's chief asset in the case was an inexhaustible fount of patience, kindliness and courage, and a fine understanding of human emotions, conflicts and disappointments, with a desire to help a fellow mortal in an upward struggle from a mental upheaval to sanity and health.

The gradual awakening of her faculties was, in no small measure, due to the nurse's untiring efforts in rousing the patient's interest in herself, in stimulating her pride in her appearance, in awakening in her a desire for resuming her social contacts, and in quickening her dormant memories by talking to her of things that seemed to please and make her eagerly happy. One cannot overestimate the wonderful influences for good that personal attentions, individual care, and intelligent understanding may have in such cases.

Character[1]

CAVA WILSON, R.N.

THERE is no profession from the members of which greater purity of character and higher standards of moral excellence are required than that of nursing. Everyone who has entered the profession has incurred an obligation to maintain its dignity and honor.

Few young women realize that learning how to perform nursing duties is the smallest part of the training process, that the drilling and disciplining of the woman inside the nurse, the development of a right attitude of mind and right habits of life, are the most difficult as well as the most important part in the making of a nurse.

Character is the greatest of all God's gifts. Without character we might as well walk on all fours and wear the fur skins of animals, for a person without character is lower than the beast.

The Grading Committee is doing much to advance the nursing profession. Our training schools are now demanding high school diplomas as entrance cards, a fine educational uplift, but—are we paying as much attention as we should to character? Are our girls better women after they leave our training schools than they were when they entered their walls? Are all the girls we take into our profession fitted to become nurses? Nursing is not just a way of making a living; it is a noble calling, a vocation, a profession. It takes women with character to make Christian nurses; they must have will power, they must have self-control, they must be patient, kind and true.

This work is the continuation of the Savior's work, helping others. When we are helping bring the body back to health, what are we doing but fortifying the fortress of the soul?

If, after a girl has been in training for two years she still has a weak, questionable character, what right has she to graduate and join our army of workers? What does that girl do but bring shame upon our profession as well as herself? Are the students entering training too young, before they have developed a hold upon themselves and are they thereby unable to fight the temptations of life? Are they getting the proper protection and guidance from the schools? Every girl should be protected as if she were an only child of devoted parents. Those who are responsible for the development and training of our nurses, as well as each individual, should be as Caesar's wife—above suspicion.

[1] Read at the twenty-fifth anniversary of the Louisiana State Nurses' Association, New Orleans, November 29.

A Day in a Greek Gymnasium

ELIZABETH SHEPPERD MILDNER

JUST outside the walls of Athens, the marble portico of the palaestra gleamed a brilliant greeting to the early athletes who had begun to gather in the library, the baths, and music room, and on the field of the large gymnasium. Now only a few groups stood about, but soon the whole youthful free-born population of the city would be thronging here for at least an hour of daily training.

One group of three young men particularly attracted attention. They had cast off their white himatia, the simple garment worn by Greek men, and were standing like strong and graceful statues come to life. With oil from little round flasks, called oinochoi, they were anointing their gleaming bodies in order to increase their suppleness and endurance. These youths had come here so early in the morning for their daily work-out preparatory to entering the greatest athletic event of their world, the Olympic Games, which were held every four years at the beautiful Pan-Hellenic sanctuary of Olympian Zeus.

The tall, broad Athenian with bronze hair and noble brow, who vied with Apollo himself in beauty, was Hipponax, son of Hyponachus, a most promising entrant in the Great Games. Standing next to him was his cousin Androcles, wiry and slight of build, and Endius, their friend, finely proportioned and full of grace, completed the group. All three belonged to that favored class which took war, politics, and athletics for its profession and left the work of the world to be done by slaves.

KRATER IN THE BROOKLYN MUSEUM

Three draped athletes, one with weights for leaping, the other two with strigils. This is red-figure Athenian pottery of the fourth century B. C. It has a beautiful black glaze with the figures left in the red of the clay

They were waiting for their trainer, Leon, a man of middle age as all the trainers were. Soon they spied his blue cloak coming through the portico. Leon was particularly skilled in training the ephebi, youths from eighteen to twenty-four years of age, who were just entering political and social life. The younger boys, from twelve to eighteen, had their own special training quarters and trainers. The men from twenty-four to thirty had still other quarters. Each group participated in the same set of exercises, the great pentathlon, with modifications to suit its particular requirements. The pentathlon consisted of five exercises, honored from time immemorial at the Olympic Games, running, leaping, wrestling, javelin and discus throwing.

Running, being the simplest exercise, came first; so, when Leon came up to the young men, after an exchange of greetings, he set them to the

*A class in Personal Hygiene was so interested in Mrs. Mildner's presentation of Greek athletics as depicted in art that, on suggestion of the instructor, Mrs. Mildner prepared this article for the *Journal*.

KRATER IN THE BROOKLYN MUSEUM

Here can be recognized the dance described in the story. Notice that the trailing ivy around the neck is in black glaze on red ground instead of red left in relief with black background as in the band of figures below

mark for the foot race. The friends crouched low over the line, with finger tips pressing the sandy track, waiting for the signal. This released three young bodies which flew down the course with the grace and speed of greyhounds, for it was not only speed, but grace also which the Athenians prized. At the finish Endius led, and the enthusiasm was high as his companions congratulated him on his success.

Next Leon started, in businesslike manner, the leaping contest. Each lad took two of the dumb-bell shaped objects from the wall of the neighboring portico. Grasping one in each hand, to give balance and momentum, one after the other the youths swung them back and forth several times, then let them fly backward as they leaped forward through the air, alighting some feet away. The distance was carefully measured and Hipponax was found to have outstripped his fellows.

The event which followed was wrestling. Before this contest was started, each dusted himself with fine sand to give his opponent a grip on his oiled body. First Endius and Hipponax strove together until the latter was rolled over on the ground. Then Androcles, fresh and determined to win, grappled with Endius and gave him a tumble he did not soon forget. At last he too went down in a cloud of dust, leaving Androcles undisputed victor.

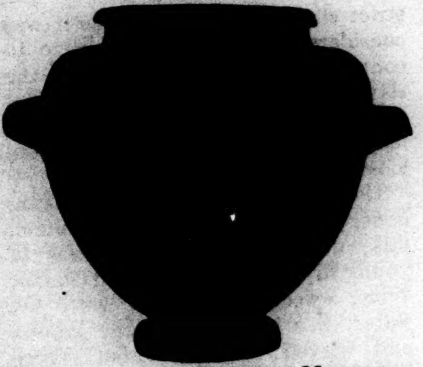
Each now had won an event, and after a short rest, they pressed eagerly forward to the javelin throwing. The long graceful shafts were brought out, carefully hefted, poised, and played with, until each felt confident of his weapon. Then, one by one, they took their places, drew back the delicately balanced shafts and sent them flying towards a shield some rods away. Although the others came near the mark, Hipponax alone hit the boss of the shield and was again acclaimed the victor.

The last event of the pentathlon, discus throwing, was now to take place. Spectators at the games watched for this event with the greatest eagerness. It was not only the most difficult but also the most beautiful game, as it displayed the grace and power of the body to best advantage. The discus, lens-shaped and of heavy metal or stone, was very hard to manage. Each youth selected one, carefully fitted his wrist into the shallow side, tightened his fingers over the edge and balanced the rest of the discus on his forearm. Before throwing, each took an upright position with one foot advanced. A forward stretch of the arm, a swift and vigorous pull backwards, a graceful body in full swing, an outshot arm, a discus flying down the course! Two others followed the first, each

going farther than the last. Hipponax was the victor. He had finished the day's sport with two more victories to his credit than either of his companions, who eagerly praised his strength and skill. There was not a trace of envy displayed, for Athenian boys learned in early youth that grace of body, mind, and spirit were equally important and that envy marred this grace of mind and spirit.

Affecting a mock celebration, the two defeated contestants called upon six young men from a neighboring group of athletes in the now crowded palaestra to help them acclaim the victor. On state occasions, the victor of the Olympic Games was always welcomed to his native city by a band of young men and girls dancing and singing and playing upon musical instruments. The newcomers entered into the spirit of the sport with zest. One grasped a bronze tripod, the customary gift to a victor, and set up an animated dance. Another put on a long himation, making himself look like a dancing girl, and called for a slave to bring tambourine and flute from the music room. When these appeared, he handed the flute to a third youth, flourishing the tambourine himself. The three whirled in a merry dance to the sweet notes of a hymn to Nike (Victory), which the flute boy blew from his double pipes. Modest Hipponax stood, crowned with an olive wreath placed upon his brow by his cousin.

Seeing that the revelry was about to subside, Kedias suggested that, as it was already mid-afternoon, the whole company prolong the celebration with a banquet at his expense. Although it was not customary to hold such affairs in the gymnasium, he proposed that they banquet then and there. By this time the crowds of athletes were thinning out. Slaves



AMPHORA IN THE BROOKLYN MUSEUM

Two men reclining on cushioned couches with serving tables holding food in front of them. They are conversing with a flute player about their evening's entertainment

were sent for couches, food, wine, and entertainers. Meanwhile, the youths scraped the dust-caked oil from their bodies with strigils, scythe-shaped and of bronze or bone, which were hanging from pegs in the wall of the portico. Then they disappeared into the beautiful marble baths and came out refreshed for the feast.

The slaves brought the couches and set them in an open triangle, piled them high with red, blue and yellow cushions, and set a serving table in front of each. The youths draped themselves with care in their long, graceful himatia and found their places on the couches, reclining with their weight on the left arm so that the right was free. The right knee was raised and the left thrust under it. The slaves brought garlands and crowned each guest before serving the food.

The Athenian fare was simple and wholesome, consisting of fowl, fish, vegetables, and fruit, all served in separate courses on beautiful pottery plates decorated with athletic scenes. Fingers took the place of knives and forks at this meal. During the meal

strict silence was observed as it was considered a breach of etiquette to converse while eating. But when the slaves had brought basins of water and linen towels and had washed the hands of the guests, all tongues were loosed.

During the symposium, or drinking bout, which followed, there was much talk, principally of the chances of young Hipponax in the coming Games. Wine, sweet and mixed with sea water, was brought in large kraters and served with a ladle. These kraters and the stemmed goblets or kylikes from which they drank were decorated with scenes of athletic contests, dances, and banquets such as they had been enjoying. While the symposium went on, a band of trained musicians, playing the flute and dancing, regaled them with songs of famous athletes till the setting sun warned them that the day was done.

Then Hipponax, Androcles and Endius, not wishing to break their strict training and indulge further, said farewell and made their way out of the palaestra to renew their energies in sleep for another strenuous day in the gymnasium.

Pronunciation

Hipponax—Hip′-pon-ax, i as in *hill*, o as in *ponder*, a as in *add*.

Hyponachus—Hy-pon′-a-chus, y like i in *high*, o as in *ponder*, a as in *alive*, ch like c in *cushion*, u as in *us*.

Androcles—An′-dro-cles, a as in *and*, o as in *droll*, e like ea in *eat*.

Endius—En-di′-us, e as in *end*, i like ea in *eat*, u as in *us*.

strigil—stri′-gil, i as in *sting*, g as in *girl*, i like u as in *us*.

palaestra—pal-aes′-tra, a as in *pallid*, ae like e as in *Edna*, a as in *art*.

Nike—Ni′-ke, i like ea in *eat*, e like a in *fate*.

ephebus—e-phe′-bus, e as in *bet*, ph like *f*, e like ea in *eat*, u as in *us*.

A New School for Men

A SCHOOL of Nursing for Men was opened at St. Vincent's Hospital, New York City, on February 5, 1930. The hospital, which is operated by the Sisters of Charity, has a well known school for women nurses which dates back to 1892.

The new school opens under most favorable conditions. Frederick Jones, who established an enviable record while in charge of the Mills School for Men at Bellevue Hospital, working under Sister Felicite, Director of the Hospital, is director of the new school.

The school has its own building, near the hospital, in one of the handsome old residences of downtown New York, which has been remodeled for dormitory and classroom use.

The opening of a new school for women, except under ideal conditions, would hardly be a cause for rejoicing at this time, when many private duty nurses are unemployed. A school for men, however, is in a wholly different situation, as there have been no evidences of overcrowding in those parts of the nursing field which are particularly theirs.

The school was blessed, at the opening exercises, by the Very Reverend John F. Brady, D.D., and congratulatory addresses were made by Dr. George David Stewart, Dr. George O'Hanlon and Nina D. Gage, Executive Secretary of the National League of Nursing Education.

Journal Index Ready

THE Index for the 1929 volume of the *American Journal of Nursing* is now ready. Ask for it! Do not make the mistake of binding your magazines without it.

Uncle Sam Wants to Know, What Kind of Nurse Are You?

WHEN the census enumerator comes to your home, on or about April first, what will he be told about your occupation? What will the stay-at-home member of your family or your landlady tell him in response to this question? Suppose, just for fun, you go home tonight and ask this person what she would say. In many instances she would probably tell the enumerator simply that you are a nurse, considering this term sufficiently descriptive to meet all needs.

But is it? The Bureau of the Census classifies nurses in the three groups listed below. Read them over, see in which one you belong, and decide whether or not you would like to be classed in either of the other two groups.

1. Trained nurses, including all with professional training
2. Practical nurses, including attendants at hospitals, sanatoria, and other institutions
3. Nursemaids

Trained nurses are included among the professional occupations, as classified by the Census Bureau; the other two groups belong in domestic and personal service. Had you ever thought in terms of these three groups? Probably not. Professional nurses are so inclined to associate exclusively with members of their own group that they are quite likely to forget the practical nurses and the nursemaids and to consider the term "nurse" as all sufficient and fully descriptive of their occupation. Yet, because of a tendency among nurses to return their occupation simply as "nurse," no one occupation offered greater difficulty in classification at the Census of 1920.

Do you know how you will be classified if some member of your family returns your occupation simply as "nurse"? Or as "nurse, private family"? You will be counted as a practical nurse, because all unspecified nurses are so grouped unless there is evidence to the contrary. For instance, an extremely young girl would usually be considered a nursemaid rather than a practical nurse, if she were listed simply as a "nurse." But, in general, the Bureau of the Census classifies all unspecified nurses as practical nurses. This practice which is based on the fact that it is only human to rate ourselves as highly as possible, proves to be a severe shock to members of the nursing profession when they hear of it.

The burden of proof rests upon you. As professional nurses you should instruct your families or your landladies to state your occupation so clearly and so completely that none may fail to understand. It is true that the census enumerator is told not to accept the unqualified term "nurse" as an occupation. But in the multiplicity of directions which he will receive, he might possibly overlook this point or consider it of minor importance. Therefore, each of you should accept your own individual responsibility in seeing that your occupation is correctly reported.

Why is it so advantageous for professional nurses to know accurately how many of their number are actively at work in the United States and in the country's subdivisions? As the various nursing organizations have repeatedly pointed out, this information is of the greatest value to your profession. Legislation affecting nurses, questions of registration, salaries, hours of employment, geographic

distribution, unemployment, the establishment of training schools and their educational requirements hinge to a certain extent upon the number of professional nurses at work in a given state or city, as well as in the country as a whole. The advantage in having accurate numerical data will accrue particularly to your own profession, though explicit returns will unquestionably serve to lessen the Census Bureau's difficulties in classifying nurses' occupations.

The preferred term to use in describing your occupation, if you are entitled to it, is *registered nurse*. *Graduate nurse*, *professional nurse*, and *trained nurse* rank next in desirability. *Public health nurse* and *student nurse* are acceptable terms; but *private duty nurses* should be extremely careful to state that they are registered, graduate, professional, or trained nurses doing private duty work. To a census enumerator the terms "nurse, private duty" and "nurse, private family" sound very much alike. Hundreds of nurses were classified as practical nurses in 1920 because their occupations were given as "private nurse" or "nurse, private home." How many of these nurses were professionally trained? No one knows!

In addition to your occupation the census enumerator will ask for information regarding your place of employment. Some acceptable ways for you to return your occupation and place of employment (or industry) are as follows:

Occupation

Registered nurse
Graduate nurse
Professional nurse
Trained nurse
Superintendent of nurses
Supervising nurse
Director of nurses
Educational director of nurses
Student nurse

Place of employment (*or industry*)

Private duty
Public health work
Hospital (or any other institution)
Industrial plant (any factory)
Health department (city, county, or state)
School or college
Visiting Nurse Association
Army, Navy, or Veterans' Bureau
City, county, or state
American Red Cross
Any health agency
Any social service agency
Any religious or charitable organization
Department store

To be acceptable, any entry under "Occupation," in the above list may be combined with any appropriate entry under "Place of employment." The place of your employment is of minor importance, however, provided you clearly define your professional status under "Occupation."

Although the 1930 census statistics will probably not distinguish between private duty and public health nurses, it is, nevertheless, highly desirable that you form the habit of stating, not only that you are a professional nurse, but the type of nursing in which you are engaged, as suggested above. Educate your family, once and for all, in the proper way to state your occupation. If, through your negligence, your occupation is simply given as "nurse" or in some other unclassifiable way, remember that you are reducing the number of professional nurses and at the same time you are swelling the number of practical nurses in your city by one!

This is an appeal to your professional pride. Will you see to it that your occupation is returned in such a way that the world may know that you are not a practical nurse, nor yet a nursemaid?

Bedside Nursing[1]

From the Viewpoint of the Private Duty Nurse

EUGENIA KENNEDY, R.N.

ALTHOUGH technic is constantly changing, methods improving, and the teaching in our schools growing better and more comprehensive, the old problems of private duty have to be faced along with the new ones that have grown out of this fast changing world in which we are living today.

Just what does bedside nursing include for the private duty nurse? Surely it means more than just nursing technic. It means all of those things that enable the nurse to take care not only of her patient's body, but the mind and soul as well. The good nurse should be able to make adjustments that will enable her to fit in with the patient, the doctor, the patient's family, friends and servants. How many of us have gone into homes to hear stories of nurses who were good, but—; who were skilful, but—; and after the "but" comes a long list of such faults as do not show in hospital life, where the routine and the many rules and the constant supervision make them less likely to become prominent. "She bangs the door!" "She breaks the china!" and so the story goes.

The relation between the nurse and patient from the first should be an amicable one. Nursing, in a way, should be an exponent of our own spiritual state. In the first place, we should be in entire sympathy with the sick. By sympathy I do not mean sentimentalism. These two emotions are very unlike. If we could put ourselves in the place of the patient, many times we should find that perhaps we should do things differently. A thought that sometimes helps when patients are trying is this: "Never forget that the patient is sick and I am not." Tact is worth so much. If we try to feel as the patient does, instinctively we know how to treat the patient, and will perhaps be often rewarded for some little deed by the pleased surprise with which she will say, "How did you know I wanted it done?" The pillows may be flat and hot, the hair uncomfortable, the undersheet wrinkled or untucked. All these and a dozen more little things can be arranged so easily, and they mean so much to the comfort of the sick.

A patient appreciates the nurse's interest in her personal belongings. She likes to have her top dresser drawer, her various boxes, kept just as she keeps them. We may think it very foolish for her to have three piles of handkerchiefs, each a different age or degree of fineness, but if that is her way, she will be better satisfied if she knows we will not lay a fine handkerchief over a common one. Hanging the clothes up carefully, putting the shoes away in the proper place, folding the pretty kimono and laying it away carefully, all help in keeping the patient satisfied. These points seem insignificant, and yet when we look about us we find that it is in some of these seemingly unimportant points that we fail.

Some years ago in an English magazine devoted to nursing, there was a very clever article on "Talk." The writer, a nurse, thought subjects were scarce. She says:

[1] Read by [illegible], R.N., at the meeting of the [illegible] Division of the A. N. A., [illegible], April, [illegible].

We must not talk to the patient about her own complaint, that would make her morbid; or about the doctor, for that would be gossip; or the hospital, for hospitals are full of horrors; or the other nurses, for that might lead to talking scandal; or about the other patients, for that would be betrayal of confidence.

Now what are we to talk about when a patient is well enough to talk? In this day of self-expression, surely we can find a topic of conversation. If the patient is interested in books, we have a never-failing topic. If we have visited interesting places, that always helps to fill in the vacant gaps. Nurses have disseminated culture in the homes they visit, just as teachers do in the schoolroom. The difference is in the intimate association of the nurse. Every nurse should read the daily papers so as to keep in touch with all current events, political, religious or social. In this way, she has at her command a fund of information and material for conversation.

One often hears the private duty nurse deplore the necessity of remaining with a patient during convalescence. "I wish," such a one may say, "that I never need stay with a patient after the temperature has been normal for days." Perhaps this feeling is caused by the atmosphere of the hospital which has, during training, been the nurse's home. The hospital patient leaves at the earliest possible moment of recovery, to make room for someone else. Nurses seem to feel that caring for the convalescent is not nursing, but they are mistaken. When a temperature has to be taken but once a day, or when the doctor makes visits only twice a week, when all the routine of the sickroom gives way to a more natural atmosphere, many nurses do not feel at ease. They do not read aloud pleasantly and, if the patient asks for this, the reading is a torment for the nurse. It behooves the nurse to prepare herself for these periods by learning to read aloud, and to play games, and by knowing something about sewing and all the various phases of occupational therapy.

In the beginning, I said that bedside nursing surely meant more than just nursing technic. I did not mean to undervalue the need of skill and knowledge of the nurse. Recently, a friend of mine quoted a remark made by the father of a child she was nursing. This father said he thought a private duty nurse should go back to school every two years. I do not believe he is alone in that thought. Professor Charles H. Judd, in discussing adult education last year at the Louisville National Convention, said:

> I venture to advocate that the nursing profession give up the doctrine that a nurse is forever competent because at one time somebody put on her the stamp of approval as a graduate of some more or less well-equipped training school. I shall not attempt to say that every nurse should be obliged to come into a training school for one month in a year, in order to make sure that she has not contracted intellectual coma, but I am willing to assert that some continuation training in service for nurses would promote the well being of the nation.

I believe Dr. Judd is absolutely correct and, furthermore, I think that private duty nurses feel the rustiness that comes without renewal of knowledge, and I feel sure that they would welcome something that would place educational opportunities before them. Why couldn't our central directories become the life of such a movement for the private duty nurse? Not too detailed, but instruction could be provided whereby the private duty nurse could hear scientific lectures and renew thoughts on technic through demonstrations given by qualified persons.

The relation of the nurse to the doctor has changed considerably in the last years. There are many types of doctors just as there are many types

of nurses. Psychology is most helpful in teaching us how to make the necessary adjustments. Loyalty is so necessary, and yet there are times when a nurse is justified in not doing exactly as a doctor wishes if she knows that what he is doing is absolutely wrong in the immediate situation. The more faithful we are to orders, however, the more trust and confidence can be reposed in us. When we leave a case, it is only just that the doctor should know that we are leaving, and why. Records, too, should be kept faithfully. The doctor usually looks over them very carefully, but sometimes one comes along who passes over them in a lofty manner. We may conclude that it is not necessary to keep them accurately in such a case, but this same doctor some day may ask us how long ago it was that the patient's temperature took a sudden rise.

So far we have discussed the relation of the nurse to the patient and the doctor, but the nurse herself should not be neglected. To do the very best nursing possible, it is just as necessary for the nurse to be careful of herself as of the patient, though her care must be manifested in a different way. No man owning, and intelligently working, a valuable machine would keep it going at its highest speed all the time. He takes care of it, keeps it clean, renews defective parts, oils it, and then he expects it to run so many hours and to run well—to do its work thoroughly. With all its upkeep, he does not make it work night and day for weeks and months. With us, human beings, who own and manage a far more wonderful machine than any steam engine, we often hear of misuse. In the first place, we should never go to a case unless we feel well. Patients are very sensitive to the subtle influence of the one over them. They react favorably to the healthful person and just the opposite to one who is not. Proper eating, adequate rest and wholesome recreation are so important in keeping the nurse fit. The patient has so much time to think about the nurse who is caring for her. The uniform stands out and a pleasing appearance with every detail of the uniform is so important. In this connection I can do no better than relate an incident that I heard of some time ago. A nurse went to care for a patient whose first nurse had been called away, and she had not been in the room an hour before the patient called her and, taking her hand, said, "My dear, I can't tell you how thankful I feel that your dress is not too short in the waist. Miss Smith's dress was frightful." This, of course, was only a nervous woman's whim, but our success as nurses depends in many cases on just such whims. Nurses should be very careful not to contract annoying habits—frequent clearing of the throat, sniffling, kissing of patients, and many others. A "lady" in an emergency does many things that are usually left to servants and so must the nurse—here, I believe, we sometimes fail. If a nurse can help by doing the shopping, planning a meal or even preparing the patient's food — there is no reason why she shouldn't. Anything that a nurse can do to relieve the patient's mind or to make the domestic wheels run more smoothly she should do. By some little service, everlasting gratitude is earned and recovery hastened.

Private duty nurses should keep their standards high. We should let nothing but the very best satisfy us as far as our work is concerned. We should endeavor to keep our minds well informed, full of scientific facts, skilful methods, good literature, fine

pictures, and then there will be no room for the memory of all the disagreeable things one must encounter in one's work. Again, may I quote from Professor Judd on adult education when he says,

> A third type of intelligence which I believe a nurse should leave behind is a series of references to reliable reading matter dealing with health and personal management. People want to know where to get information on such matters—witness the eagerness with which syndicated matter in the newspapers is read by the public. The well-trained nurse can do much while she is in the home by way of direct teaching of methods of hygienic living, but the lasting influence of her teaching will be greatly increased if she guides the reading that will go on after her departure.

Every nurse should be a real teacher. In fact she is a teacher whether she realizes it or not. By example, and by contact with the public, she passes on valuable knowledge.

Many times nurses are accused of not taking an active part in civic and national affairs. Here they are justly criticised as many do not even deem it a duty to vote. Who could have more influence, who has a better educational background than the nurse, to qualify for activity in affairs of city, state, and nation? Every nurse does not have time for special courses to keep in touch with civic, religious, and nursing questions, but so much could be gained by conferences with teachers, preachers, lawyers, and others who are active in such affairs.

At least every nurse should keep in touch with the newer movements in the medical and nursing world. There is no better way than that of taking magazines, especially our own magazine, the *American Journal of Nursing*. Membership and active participation in nursing organizations is important. Through their scientific meetings and institutes, much knowledge can be obtained. Keeping up with newer methods of procedures, special diets, and treatments, is the least that can be expected of private duty nurses.

One should always be loyal to her own school and hospital. It may not have been in every respect perfect, but it is not necessary to tell strangers of its imperfections. Probably those in authority are just as sensitive to its shortcomings as we are and perhaps they work even harder than we do to right its wrongs. In any case it does no good to tell others the things of which we disapproved. It may be that the rules we hated and found hard to keep are the wisest ones and, if we let strangers see that we disapprove of these wise regulations, the opinion they will form of our intelligence will certainly not be flattering. Being loyal to our own school does not mean that we should ridicule the school from which another has graduated. We should try to realize that the other school is neither wholly above nor wholly below our own, and that each has probably its own merits and its own drawbacks.

Some very awkward complications may arise where there are two nurses, and the worst, I think, is for the family to like the second nurse better than the first. This is difficult all around. The second nurse expects the first one to be preferred. If we should find ourselves in the place of the second nurse, we should remember not to gossip about the first one and retail her faults. If, on the other hand, we should find ourselves in the first nurse's place, and a second nurse is called in and preferred, we should study that person well and try to find out wherein lies her charm. Is it quietness, neatness, cheerfulness or ready tact? It must be something, and if we are clever we must see how it happens that she is preferred? It is wise not to let ourselves be jealous, but if

we use this as a time for study, we may be able to learn something that will aid us in winning and keeping the confidence of our next patient.

Why do nurses complain? In *Nurses, Patients and Pocketbooks*, the report on supply and demand of nurses, Dr. Burgess says:

> There are three things wrong with private duty: (1) There is an over-production of nurses. This results in unemployment problems which are especially acute in the private duty field, since the field must absorb all workers who cannot secure either public health or institutional positions. (2) Private duty is a free lance occupation open to all comers. Good nurses suffer from the competition of women far below their level in breeding and intelligence, professional ethics, and nursing knowledge and skill. (3) The free lance worker in nursing, as in other professions, inevitably pays for her cherished independence of action through lowered income, irregular employment and extreme professional loneliness.

On the other hand, Dr. Burgess says:

> In spite of the prevalent discontent among many private duty nurses, one fact has stood out clearly, so clearly in fact that it has been genuinely impressive, *nurses like bedside nursing*. They do not like their hours, or conditions of work, but some nurses honestly enjoy taking care of really sick patients.

This fact should never be lost sight of. In spite of the constant criticisms and the prevalent bitterness in the private duty field, many of the women who are in that field are at heart real nurses who care deeply about their work and have never lost the essential spirit of nursing. If private duty nurses are not satisfied with the profession they have chosen, the best thing for them to do is to make a change. Today, there are subsections to private duty—hourly nursing, group nursing, and general floor duty, are gaining popularity; and then, too, positions are open to the private duty nurse in industry, and in colleges and other institutions.

If the official directories or registries are to attain complete usefulness, the organizations responsible for their conduct must be on the alert to sense these newer phases of nursing as well as the changing requirements of their communities. When the profession shall have attained the goal of a network of highly efficient and ethical placement bureaus, extending the filaments of its service up and down and across the entire country, it will have gone far toward equalizing the distribution of nurses.

The central registry can be compared to a wheel of a moving vehicle, the hub—the contented public; spokes—nurses that satisfy; and these held together by the rim of the central registry. Things that make for a contented public are: (1) service, (2) nurses who give satisfaction, (3) keeping contacts between nurses and doctors and former patients. In truth, the registry centralizes the nursing profession and doctors soon realize where to call for the best nurses in the community, as a nurse who will coöperate with them is to a great extent responsible for their success. Thus it can be seen that a registry wide awake to the needs and interest of the public, and one that will be content only with nurses of the highest type, who satisfy because they are satisfied, must in the long run become, like the wheel, a going thing, and an established institution in the community.

How Many Patients?

HALF of the nursing schools in the United States are run by hospitals having a daily average of 77 patients or less. One-fourth of all the schools are run by hospitals having a daily average of 44 patients or less. Another fourth, at the other end of the distribution, have a daily average of 140 patients or more.

How big does a hospital need to be in order to run a good school? Can it be too big? Can it be too small? Are the nine schools which report a daily average of from 1 through 9 patients, and the 66 others which report a daily average of from 10 through 19 patients large enough to furnish sufficient clinical experience for student nurses? If, in order to be state accredited (and so far as present records show all of the schools reported upon in this article are state accredited) the school supplements experience in its own wards by affiliations for its students in other hospitals, how much affiliation must it have to give its students a proper clinical background?

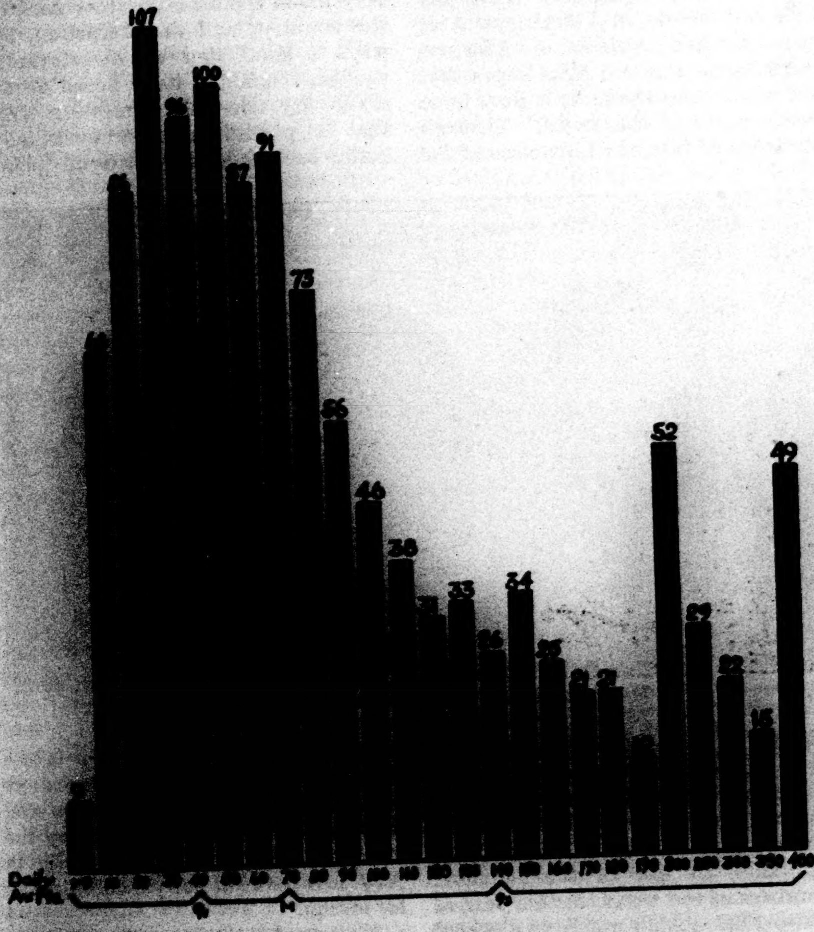
One-fourth of all the schools in the United States have a daily average of 44 patients or less; one-half of all the schools have a daily average of 77 or less. Is a hospital of 44 patients big enough? Is one of 77? The question really becomes two: first, assuming that the hospital has ample funds for teachers, classrooms, equipment, and supplementary graduate floor nurses, so that in everything but clinical material it is prepared to conduct a high grade school, how much (and what kinds!) of clinical material should be considered as minimum for a three-year course leading to the diploma and R.N.? What is the smallest number of patients which justifies running a school?

The second question follows on the heels of the first: quite aside from the amount of clinical material, can a hospital with a daily average of 10, 20, 30, or 40 patients afford the money to conduct a modern high grade school of nursing for the handful of students it can admit? Education, if it is real, is expensive; and in every profession small schools cost more per student than large ones. How large must a hospital be before it can afford to run a good school?

There are 49 schools, out of the 1,225 which have joined in the grading study and answered this particular question, which are run by hospitals with a daily average of 400 or more patients—fourteen with more than 1,000. Some of these largest hospitals are state, city, or county institutions. They have enough patients, surely, but is the clinical experience their students receive as broad, varied, and significant as the size alone implies? Is the fact that a hospital is large, a guarantee that it furnishes an adequate background? What about the other question? These hospitals are big, but are they rich? Have they the money, and, if they have it, are they always prepared to spend it in sufficient quantities so that they can maintain not only big schools but good ones?

These questions need to be answered, and the answers are probably not too difficult to formulate. Might it not be helpful if all state boards of nurse examiners and others intimately concerned with maintaining adequate educational standards for entrance to the nursing profession could agree upon some tentative minimum standards as to size of hospital and types of services which they could recommend? There is a superintendent of nurses in each one of these schools. If superintendents of nurses could know what their own profession regards as the *essential amounts and types of clinical material,*

without which no nurse should be willing to conduct a school of nursing, might they not be more alert than they now can be as to their own responsibilities? Is the profession ready yet to set such standards?

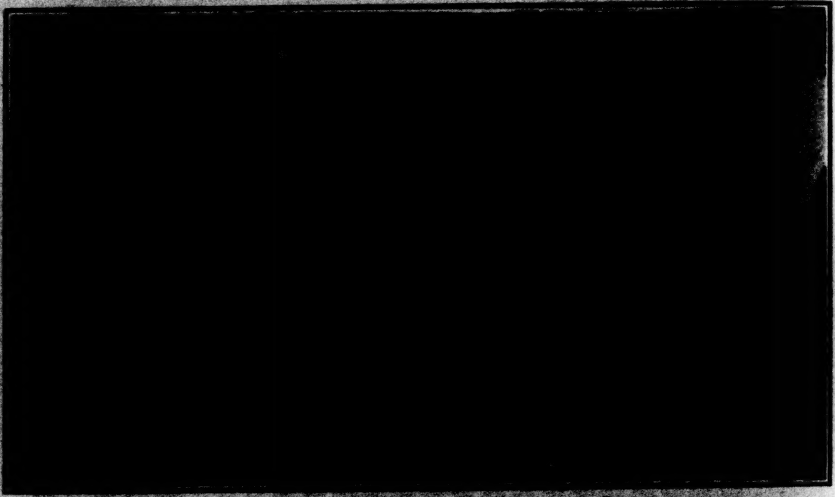


Nursing schools in hospitals with each specified daily average of patients. Height of each column indicates number of schools connected with hospitals of each given size. One-fourth of all the schools are run by hospitals with a daily average of 44 or less patients (Q_1); one-half with 77 or less (M = median); and three-fourths with a daily average of 140 or less patients (Q_3). One-fourth of all the schools in the country are connected with hospitals with a daily average of 140 or more patients.

The Nursing Situation in Italy

ALICE FITZGERALD, R.N.

TO many of the readers of this sketch the fact that the study was made in Florence will at once awaken visions of Florence Nightingale and will raise hopes that her spirit rules there, as it does in so many parts of the world. Through the irony of fate, the birthplace of the founder of modern nursing happens to be one of the most backward cities in Italy, from the standpoint of nursing education. It may seem incredible that a city of 254,000 inhabitants, in one of the foremost countries of the world, in this year of grace, 1930, should not have a school for the training of nurses, since there are many hospitals where patients are in need of care. A school was attempted, some years ago, under the auspices of the Queen of Italy, but it lasted only a few years.



Miss Nightingale's Birthplace, Florence, Italy

The information for this study was gathered almost entirely in Florence, but the general situation depicted is very much the same in other parts of the country, and dissatisfaction, always a good sign where reform is needed, is making itself heard on all sides. By the old timeworn rule that a pendulum must eventually swing back from any extreme point of good or bad, we look for better days in Italy and we will try to convey some of the high spots of hope and some of the promises held out by the efforts of many individuals ready to play their part but not yet coördinated for action.

It seemed wisest to allow Italians themselves to contribute material for this study, as an outsider could make only a superficial survey of the situation and might miss the underlying causes for the apparent weaknesses which are due to tradition and custom.

After consultation with various

people whose opinion would be of value, a questionnaire was prepared and distributed to those who are representative of the professional and social classes. In this, great help was received from Dr. Giovanni Nesti, a prominent physician in Florence; from Grace Baxter, graduate of Johns Hopkins Hospital, a resident of Florence, well known for her outstanding pioneer work in starting a nursing school which is still in existence in Naples; and from Juliet Turner, "Suora Giulia," as she is known by her patients, who is the mainspring of the free dispensary run by a foreign committee at San Domenico. She translated the questionnaire and was indefatigable in its distribution.

The questionnaire and letter were most carefully prepared in order to allay suspicion, to avoid giving offense, to secure simple and direct answers and to give food for thought. This questionnaire was undoubtedly open to criticism and the author is painfully aware of its shortcomings, but it was no easy matter to stimulate interest without arousing suspicion, to bait for answers without fear of antagonising or frightening away the quarry and finally to lead, instead of drive, the "unwilling victims" toward the desired answers. In most of the cases where personal interviews were sought, I was conscious of a very marked attitude of suspicion which was not always overcome. There had been no precedent for what I was doing, and it seemed presumptuous on my part to bother busy people about such an intangible thing as nursing. Had it not been for the valuable letters of introduction, and other assistance received from my friends, I should have weakened at the chilliness of some receptions. This, however, was a part of the game and made me enjoy all the more the visits where I was made welcome and given a whole-hearted hearing.

The questionnaire more than met my expectations, and out of forty sent out, thirty were returned, answered. In addition, a few longer statements were received, from which some extracts have been made. The results of the documents have been tabulated and will present the answers to each question, as far as possible, in terms of opinion ranging from "minimum favorable" to "maximum favorable." In some cases, questions are grouped, in order to save time and space. The digest of these questions and answers follows:

1. *Is a nurse an important factor in caring for the sick?*

The answers range from a mild "Yes" from the medical profession to enthusiastic endorsement from prominent individuals long interested in the subject. To some of these titled prominent persons, Italy owes practically all that has been done for nursing in the past.

2. *Which class of nurses, religious, professionals, volunteers, or hospital attendants have given you the most satisfactory service, and why?*

Six declared themselves for the nuns; seven were in favor of good ones in any class; nine were for professionals; one for volunteers, because of their devotion to the cause; one liked the nuns and the professionals when they were "kind"; one did not know the difference; three preferred professionals with volunteers as aides; and one very wisely said that he selected either the nun or the professional, according to the patient.

3. *Have you felt the need for better nursing service?*

The answers range from one who is perfectly satisfied, to a few timid affirmatives, and finally reach the emphatic statements that present conditions in hospitals without schools are bad, that nursing is being done by unreliable and ignorant men and women of low class whose work is not supervised.

4. *Have you been conscious of any weakness in the nursing service which might be due to any of the following causes: Poor selection? Lack of preliminary education? Lack of proper nursing training? Lack of intelligent understanding of nursing?*

The same satisfaction was expressed by the one doctor, some were vague as to weakness and cause, some look to the new law for improvement. One lays hopes in the Fascisti Party, and many refer to the spirit of sacrifice among the nuns which they seem to place above all other qualifications.

5. *Kindly outline what you think should be the qualifications for admission to the schools; the theoretical instruction which should be given. Should the student reside in the school and for how many years?*

The satisfied doctor mentioned above believes only in the Red Cross, and will not even admit that other efforts have been made. Age ranges from 18–30 to 25–60; education ranges from elementary education, which a girl completes at about fifteen years of age, to the higher education which would compare to one year or two of high school. Most of the answers favored a medium education, generally completed at about sixteen. Great emphasis was laid on the necessity for the "call or vocation." The amount of theory required ranged from "enough to fill two years" to a definite 1,000 hours in the same time. One answer asked for fifty per cent practice and theory in the first year and seventy-five per cent practice to twenty-five per cent theory in the second year. One nurse wished the subject left to each school for decision. There was practical unanimity about the necessity for residential courses of training to last two years, one advising two years in residence and a third outside, to prove that they have been properly prepared by the school. Practically all agreed that the nuns should have the same training as the lay women, if they are to nurse the sick, but a few timid hesitants added "if possible." The obstructionist believes that a recent regulation, which obliges those caring for the sick (regardless of having trained or not) to pass an examination, which being retroactive, is quite sufficient to place nursing on a proper basis. (This examination was so easy that all the hospital attendants with no preparation for nursing have been able to pass it and are therefore on an equal footing with the graduates of good schools.)

6, 7. *Do you feel that there is a demand in Florence for a school of nursing?*

Some of the answers showed a lack of understanding of what is meant by a school, as they considered that any nursing service in any hospital constituted a school. Many desire the school and want it established in the largest city hospital, though hoping for reforms and reorganization there. A few would prefer a small private hospital, with affiliations if necessary.

8. *Do you think that the average doctor would welcome a more highly trained nurse?*

Good doctors do; yes, if more education does not overlap the doctors' field; yes, when the nurse has won the doctors' confidence and has made herself indispensable to them; yes, if the nurses are "obedient" and practically all say "Yes, as soon as the better nurse is known." One answer, which seemed to be a familiar cry from the wilderness, said that the doctors are afraid of the "Signorine."

9, 10. *Do you consider nursing an adequate profession for the better class young woman and would you be willing to see your daughter, sister, or other close relative, enter the profession?*

The answers were in many ways remarkably honest: upper-class young women cannot be animated by a spirit of devotion, such questions offend Italian mentality (why?); yes, when the position of nurses is better established, when proper schools are developed only the best should be admitted; yes, if the vocation is present. One prominent titled friend of nursing feels that if the upper-class young woman wants to nurse she will enter a religious order.

11. *If the answer to the above question is no, please explain why.*

Up to now the Italian woman has had only one thought, the home; public opinion must be educated and the position of nurses must be elevated.

12. *Did not the war prove that the better educated and most socially prominent women could render good nursing service?*

An absolutely unanimous yes answered this last question.

A prominent general practitioner says, among other things, in a statement which he sent with his answers to the questionnaire:

It is necessary to call attention to the fact that until a few years ago patients in their own homes were cared for by members of the family, assisted by untrained servants. In recent years, only, doctors have begun to feel the need of nursing assistance and this newly developing profession is in its infancy, and for this reason it is not possible to compare it with the profession in other countries. Through improving the selection and the training of the personnel in Italy, nursing will be recognized as of great benefit to the people and public opinion will raise nurses to a position of importance which will command confidence and esteem.

A doctor living in Rome is markedly

in favor of the religious nurses and says in part:

> They are bound by strict discipline, . . . they act collectively and not individually, which ensures a continuity of service of value to the patients, . . . free of all outside distraction and preoccupation, and have a better psychological understanding of the sick . . . a complete shedding of personality in favor of collective life thought impossible in lay workers. Prestige of the religious dress is necessary for positions of authority. . . .

This same doctor feels that the nuns will have to comply with the law of 1925, and he has a genial idea concerning the advisability of having students in nursing in residential schools. He says "Not too much supervision in order to surprise the wrongdoer and eliminate her."

One professional nurse who is doing an outstanding piece of work typifies the intense patriotism of the average Italian. She says:

> Nursing is a new profession in Italy. . . . The Italian woman, though possessing qualities superior to those of the women of other countries, may not yet have the right temperament for the work, but time will change this.

Another nursing leader brings food for thought when she states as one of her qualifications for admission "vocation and the capacity to attach one's self to *one idea.*"

A prominent and very active volunteer nurse shows a remarkable understanding of the situation and intelligent appreciation of the many difficulties connected with the development of nursing in Italy. She writes:

> Nuns are most useful in the kitchens and linen rooms because of their wonderful spirit of order and economy; as nurses they cannot help emphasizing the care of the soul at the cost of the care of the body. . . . The present attendants in the hospitals should not be called nurses, having no education or training, but many doctors like them as they can order them about and reprimand them as they would their own servants.

Another able volunteer nurse writes:

> The nuns, if completely trained, would be most desirable because of the number available and because of the continuity of their service. . . . In Italy, doctors fear the invasion by the "signorine" which would exclude the servant class which they have been ordering about; many doctors recognize the necessity for better service and nursing care for the patient.

From Signorina Fambri, the newly elected secretary of the Fascisti Association for Trained Nurses (*Associazione Nazionale Fascista Infermiere Diplomate di Scuola Convitto*), a most interesting statement was received. Unfortunately, space will allow only a few extracts, but even these coming from a person in authority are of the utmost importance. Signorina Fambri is a graduate from the Policlinico School of Nursing, in Rome, directed for so many years by Miss Snell, and she afterwards went to England for postgraduate training. She now holds a position of strategic importance, with good opportunity for educating those "higher up," and with the power to consolidate the efforts of that fine though small group of nurses scattered throughout Italy and to develop the national association into a helpful and active body, which will represent the desires and fulfill the hopes of the nurses of that country. She says:

> Nursing requires culture and preparation in order to meet adequately the great responsibility faced. The moral and political conduct of the applicant must be studied before admitting her to the school. A three years course is best though present law only requires two years and no time allowance to be granted for previous volunteer training or special educational qualifications. It is a mistake to make night duty a twelve-hour duty and a two to three months' assignment. This year an intensive program of propaganda in favor of nursing will be initiated in all the upper schools for girls. A pamphlet entitled *Italy Wants Nurses* will be published, conferences will be held and articles will appear in the

newspapers. The nuns should train as the professional nurses do and their schools (only one in Turin exists at the present time) be supervised and controlled by government nurse inspectors. Though doctors in general are opposed to the introduction of the more educated nurse, wherever they have seen her at work in the wards, they have been won over.

Dr. Dotti, a government official, actively interested in nursing, recognises the difficulties facing any necessary reform along these lines:

> Few institutions are ready for the establishment of a school unless completely reorganised beforehand. So far the doctors have been obliged to be satisfied with poor nurses, no others being available for their private patients.

Dr. Dotti uses a very picturesque saying to illustrate this situation, saying that they have had to "joyfully celebrate wedding festivals on dry figs," the least festive of foods! He believes that "the professional nurse with the volunteer as aide or apprentice is the best combination." He believes in the residential nursing school "if well disciplined," but does not think it indispensable.

From Miss Turner we received a statement entitled "the voice of the people." Miss Turner decided that she would discuss the questionnaire at one of her weekly health conferences with patients.

Her audience was made up of the wives of gardeners, of servants, of dressmakers, and so forth, and of several school teachers from the neighborhood. The following reactions are quoted:

> Welcome rural nurses when doctors are not available. . . . Nuns are best for moral assistance. . . . The present hospital attendants are not good; they lack humane instincts and attend only those who can tip them. . . . Age of eighteen is most suitable. . . . The school teachers thought that the culture of a girl of eleven was sufficient. . . . The nurse must come from a good family in order to impress the patient. . . . Nuns should be fully trained or kept in the kitchen and linen room. . . . Signorine from good families work more willingly than the others. (A tribute to Miss Turner and her colleagues.)

From this material it will be gathered that the difficulties facing the development of modern nursing in Italy are mainly connected with tradition, with ignorance and, above all, with a lack of understanding of the subject. The situation is undoubtedly improving and a rather promising period of transition is under way and making itself felt.

The schools for nurses in Italy are to be found in most of the important cities. There are three in Rome, the Regina Elena of the Policlinico, the Red Cross School and the San Gregorio, directed by the Blue Sisters, an Irish nursing order. In Milan, we find the Red Cross School of the Principessa Yolanda; in Naples, the Croce Azzura (Blue Cross) founded by that outstanding friend of nurses, the Princess Strongoli, under the wise guidance of Grace Baxter, still the moving spirit of the school though she no longer lives in Naples. In Trieste, we find the school Regina Elena; in Turin the school of San Vito, for the religious Sisters only, and in Venice, the school of the Countess Nani, connected with the large city hospital there. The Red Cross has also established a school in Bari and more lately in Bologna and Bolzano.

These schools are the hopeful signs of the time in Italy, for they represent a definite effort to standardise the training of the nurse according to the accepted idea of what modern nursing should be. High patronage looms large in any undertaking in Italy, and it has undoubtedly been nursing's fairy godmother. Without the help of fine titled women, the nurses would have found themselves today still struggling against impossible odds in

the schools and in the public health field. It is to the great credit of these patronesses that they were among the first to recognise the necessity for reform through promoting nursing from its volunteer stage into the more stable professional stage. Now the schools have given modern nursing the standing it should have, but they have not yet made any deep impression on public opinion, nor any visible dent on prejudice due to tradition, as personified by the "old guard" of the medical profession. The "old, old guard" has been served faithfully and loyally by the Sisters for so long that they resent the new movement, as they see in it a reflection on the services rendered by the Sisters. The "young old guard" think less sentimentally about the Sisters, but they look with real displeasure on any movement which will deprive them of the services of the servant-class attendant, whom they can command as they please; mere puppets who laugh with them, dance for them and fetch and carry for them!

The "old guard" is the real obstacle to progress in nursing, but its ranks are thinning out and the nurses are fast gaining friends among the fine doctors outside, who know them and appreciate what they stand for. With these allies, with the good will of their prominent friends, with the number of schools increasing, and last but not least with the Government taking a hand in the cause, the future looks much brighter. The nurses can not afford to rest on their laurels yet! . . . There is still a great deal to be done to educate the public and to secure active coöperation from doctors and others. During my interviews, I was often impressed by the fact that although the doctors wanted reforms in the hospitals and better training for the nurses, none of them were willing to fight for these objects. They wanted the other man to do it. They were good negative supporters but not the positive kind that really counts. Even among this group one hears the deep-rooted fear of the unknown in the following remarks:

> I cannot understand calling on a sick patient and giving a nurse orders for twenty-four hours' care. I would never trust a nurse that far. . . . English and American doctors trust nurses too far. . . . Having doctors and nurses of the same social class here would lead to social relations which might be easily misconstrued. . . . If an Italian doctor was as polite to an Italian nurse as a foreign doctor is to a foreign nurse, he would be accused of being too intimate with her. . . . In England I saw doctors greet nurses with the greatest respect when entering a ward; here, the nurse must disappear when the doctor enters.

The nursing profession of Italy cannot forget what the Red Cross has done in developing nursing along high standards and in showing, from the early days, a sympathetic understanding of the need for change and improvement in conditions existing before the war. The Red Cross shows its appreciation of modern nursing by continuing to establish schools for the training of the professional nurse, a mandate which it has received from the Government. It is, perhaps, a source of regret that the intense nationalistic trend pervading Italy today should have made itself felt in the field of nursing. There is much of value to be learned from the fact that nursing is universal as well as national in character; that each country has studied, and adopted from other countries, that which was considered good and suitable for home consumption; that one can always teach others in exchange for the lessons learned and that by adopting the best from others we shorten our own period of probation and struggle. Life today, whether full of play or of work, must be a big game of give and take. If Italy takes

today from the wealth of experience of other countries, she will certainly to-morrow give in exchange from her own experience.

The situation in Italy is most interesting and offers problems which are not met elsewhere. The nurses are becoming conscious of many of them. That so many of these fine women have been working and struggling in their own restricted field without the stimulation of knowing what others were doing, and without the help which comes from organization, is much to their credit. There has been little contact between the nurses of one city and those of another, in fact many nurses are ignorant of what their nursing neighbors in the same city are doing. Now this is being overcome through the efforts of the new association and of Signorina Fambri.

The National Association, as it is now organized, can only be considered a stepping stone towards a permanent and more autonomous nursing organization, as soon as the leaders in the profession are strong enough to assume the responsibilities connected with leadership.

To our colleagues of Italy the American nurses will surely want to send their best wishes and their assurance of continued interest in the struggle for a cause which is also their cause

Measles

1. Infectious Agent. Unknown.
2. Source of Infection. Buccal and nasal secretions of an infected individual.
3. Mode of Transmission. Directly from person to person; indirectly through articles freshly soiled with the buccal and nasal discharges of an infected individual. The most easily transmitted of all communicable diseases.
4. Incubation Period. About ten days.
5. Period of Communicability. During the period of catarrhal symptoms and until the cessation of abnormal mucous secretions—minimum period of nine days; from four days before to five days after the appearance of the rash.
6. Methods of Control:

(A) The infected individual and his environment—

1. Recognition of the disease—Clinical symptoms. Special attention to rise of temperature, Koplik spots and catarrhal symptoms in exposed individuals.

2. Isolation during period of communicability.

3. Immunization—By the use of the serum or whole blood of convalescent measles patients, or of any healthy adults who have had measles, given within five days after exposure to a known case of measles, the attack in the exposed person may be averted in a high percentage of instances; if not averted, the disease is modified. Given later, but at a time prior to the clinical onset of the disease, convalescent serum usually modifies the severity of the attack and the patient acquires the usual lasting immunity of the disease.

4. Quarantine—Exclusion of exposed susceptible school children and teachers from school until fourteen days from last exposure. This applies to exposure in the household. Exclusion of exposed susceptible children from all public gatherings for the same period.

5. Concurrent disinfection—All articles soiled with the secretions of the nose and throat.

6. Terminal disinfection—Thorough cleaning.

(B) General Measures—

1. Daily examination of exposed children and of other possibly exposed persons. This examination should include record of the body temperature. A non-immune exposed individual exhibiting a rise of temperature of 0.5° C. or more should be promptly isolated pending diagnosis.

2. Schools should not be closed or classes discontinued where daily observation of the children by a physician or nurse is provided for.

3. Education as to special danger of exposing young children to those exhibiting acute catarrhal symptoms of any kind.

4. In institutional outbreaks immunization with convalescent serum of all minor inmates who have not had measles is of value in checking the spread of the disease and in reducing mortality.—From *The Control of Communicable Disease*, published by the American Public Health Association, 370 Seventh Ave., New York.

How May a Nurse Find Happiness in Her Work?[1]

GRACE H. CAMERON, R.N.

IT is a pleasure to be associated once more with a group of women who are doing such worth-while things. It was suggested that, whereas, at conferences of this work all varieties of problems are discussed, instruction in new methods given, and work from every angle stressed, it would be well to have a reminder of the subjective reaction—Is there satisfaction and compensation in a nurse's work? Each one will have to answer that question, for herself, but I shall try to show how to gather in a bit of happiness.

Robert Louis Stevenson has said: "Our aim in life is the only fortune worth finding—and it is not to be found in foreign countries but in the heart itself." Nurses have an aim. From the first day in the school of nursing we are taught to bear ever forward to high attainments. To my mind, nurses are among the outstanding successes of this century. Do you remember that Sairy Gamp was the typical nurse of the Nineteenth Century? How far we have come in these sixty years since Florence Nightingale started to materialize her superb vision.

Philosophy teaches us that all success depends on three fundamental qualities: courage—to make a beginning, to overcome obstacles and to keep going; skill, for the present civilization has no prominent place for the unskilled worker; and vision. It is really the vision that counts. A nurse is more or less restricted. She is constantly giving and in time her work becomes hampered because of the narrow outlook and dryness of inspiration. The earnest worker becomes depressed. Is it worth while? This is a material age. There are not many nurses living in "millionaires' row." One worries over the dollars, and at times even the cents seem the one worth-while thing.

But do dollars and cents count most in our life? Yes, some of us continue to say. But we have lost the vision. We have been so engrossed in the cares of the moment or so self-centered that we fail to hear the still small voice. We are blinded to the smile behind the frown, the love back of the harsh word, the courage that causes a moment's whimpering. In a book, *The New Morality*, by Durant Drake, he says, stated briefly, "Much of the gloom and depression of spirit from which people suffer is due to mere laziness and stupidity." Shall we accept that statement?

"People will take so little trouble to cultivate the technic of happiness." Did you ever stop to think that there is a technic to happiness? Do we not consider, rather, that it is our inalienable right? Happiness, then, is only attained by a determined effort. And further on Mr. Drake gives four rules to counteract depression which you will see represent the effort you must make:

1. Keep good health. Strive after it. Hold it.
2. Have positive interests.
3. Cultivate courage—do not let trouble overwhelm you. Trials and worries are a part of life.
4. Be childlike—keep alive a sense of the wonder of life.

Oftentimes the beauty of a picture is lost because one is too near. Stand back, get the right perspective, and the loveliness of the painting is seen. So, you nurses, stop a moment from

[1] Read before the Nursing Section of the Annual Health Conference of the State Board of Health of Arkansas, October, 1929.

time to time, stand back, look at your work, measure it with the rule of true values, and you will surely find a satisfaction of the spirit.

You know the story of the Bluebird of Happiness. Not only must you make an effort toward happiness but you must look for it, and remember that happiness is not regulated by material possessions. Get rid of envy. What does it matter about the other one? It is you yourself who counts. Weed out that "follow the leader" habit. "Everybody's doing it—everybody wears one."

What difference does it make? Build for yourself, and preserve your vision. If each nurse would tabulate, honestly, the subjective returns of each case, put down in orderly columns the encouragements, the discouragements, the trials, the joys, just as one so painstakingly makes notes on symptoms, pulse, temperature, etc., she would be surprised to find how a ray of happiness will pierce the gloom of depression. Just the taking of time to be quiet is a long step toward contentment.

I haven't given you any concrete examples of the joys, satisfactions and happiness that come into a nurse's life individually. Each one must find her own contentment. But as a group, we must be proud and happy over the achievements of nurses, the success of prenatal and prophylactic work in reducing infant and maternal mortality, the marvelous fight against infection, the building of a healthy citizenship through constructive work and the teaching of hygiene and sanitation, the social service work that is building up a better family life.

When we are down in the depths let us remember the wonderful women who have gone ahead of us and builded unfalteringly this splendid profession of nursing.

This little poem was dedicated to a pioneer nurse by Rev. Joseph C. Booth and appeared in the April, 1929, number of the *American Journal of Nursing*.

The Faithful Nurse

The art of nursing is a gift of God,
Where cultured brain with heart and hand unite
And tireless feet that tread, as Jesus trod,
In healing ministries. The nurse—with light
Of knowledge she obtained in nursing schools—
Combining intellect, affection, will,
Now executes the doctor's strictest rules,
With tactful art and scientific skill—
What patience and endurance she maintains,
Inspiring hope within the patient's breast;
In that sickroom the white-robed maiden reigns,
Demanding God's pure air and peaceful rest.

[Reprinted because it so well rounds out the gracious thought of the author.—ED.]

Effects of Antepartum Care of the Mother

THE conclusions are: *First*, that antepartum care of the mother has reduced infant mortality due to natal and prenatal causes and can reduce it still further; second, that the reduction in maternal mortality noted has been chiefly due to a decrease in deaths from albuminuria and convulsions, and that antepartum care of the mother has been an important factor in that reduction; further that the extension of adequate antepartum care would prevent many deaths from this cause; third, that although antepartum care of the mother has not diminished the mortality rate from puerperal septicemia, reduction from this cause may be anticipated as a result of a more thorough understanding by the public of the danger of septicemia following induced abortion.

Our final conclusion is that the promotion of antepartum care of the mother through public health programs of work has effected reductions in infant deaths from natal and prenatal causes and resulted in a lower mortality rate for mothers from puerperal albuminuria and convulsions.—Blanche M. Haines, M.D., at the annual meeting of the American Child Health Association, October, 1929.

The Development of Office Nursing[1]

ANNE P. MARTIN, R.N.

THIRTY-FIVE years ago the duties of the doctor's "office girl" were quite different from those of the physician's assistant, as she may be termed, today. The professional woman was scarcely heard of. The young woman who chose to find employment in a doctor's office needed no special training. All that was expected of her was ability to answer the telephone, relay messages, and do a very simple kind of bookkeeping. It was not really necessary for her to cultivate the art of being pleasant. If an emergency call came, she must help the doctor off at the earliest possible moment. If patients came to the office, she merely entertained, or bored, them until the doctor appeared.

But the statisticians tell us that more progress in the invention and improvement of scientific devices for saving labor, life, and limb has been made in the past hundred years than was made in four thousand years prior to that time. No profession has been more keenly alive to this than the medical profession. No place has undergone more changes than the doctor's office. Every change has made the equipment and the duties of the users more complex and more exacting. The old farmer who sat bewildered in a modern physician's up-to-date office expressed the idea in his own language: "I jes' tell you, when a man practices medicine these days he shore has to keep a lot of inconveniences 'round him." One of these "inconveniences" is the office nurse, yet she is, in a way, the physician's right hand.

Oliver Goldsmith in his "Deserted Village" tells how the peasants idealised the old parson,

> And still they gazed and still the wonder grew,
> That one small head could carry all he knew.

The condition is practically true of the capable physician, yet it is a physical impossibility with all the present-day complexities for his hands and mind to execute all the orders of a day's work. An assistant has become a necessity. Since her work is so closely allied to that of the physician, the preparation of the office nurse must be of a superior type. She must be able to supplement his work at every turn.

In the offices of the up-to-date, modern hospital the well-trained nurse is more in demand than in the private physician's office. Here the various specialists are colonized in order that they may coöperate. This system of correlation calls for a capable assistant. In the march of progress, as finer technic developed, it became necessary that the office nurse be trained to meet the demands of the specialist. She must be versatile. It goes without saying that she needs a high school education and at least three years of thorough training as a nurse. Then she must continue to be a student. She must keep informed as to the newer methods of medication and treatments. She must know the preparation of various intravenous medications, and be able to give them in cases of emergency. It is greatly to her advantage, as well as that of her physician, to be prepared to do dressings and to assist in minor operations.

An elementary knowledge of laboratory work, such as routine blood counts, urinalysis, blood ureas and blood sugars, is another asset. The well-trained office nurse today must

[1] Read before the Virginia State Nurses' Association, Staunton, Va., May 24, 1929.

know how to make basal metabolism tests, calculate them, and file her reports for the physician's use. She must also understand the functions of the electrocardiograph, be able to make the tracings and develop them. In the modern office the business side of a day's work is vastly important. The keeping of records, communicating with patients, and transacting various matters of business, make a knowledge of shorthand, typewriting, bookkeeping and filing almost a necessity. Much of this tedious, but important, work falls to the lot of the office nurse.

The time has come when the hospital which wishes to give the best to its pupil nurses must include in their training a course in office nursing. No one can continue to work effectively without some social stimulus. "Iron sharpeneth iron, so man sharpeneth the countenance of his friend." In the hospital office there is daily contact with persons from every walk of life: those who are hurried, and those who are slow; those who are sick, and those who think they are sick; some who are happy; many who are distressed and anxious. This means that the office nurse has it in her power to make her hospital and the physicians whom she represents popular or unpopular. "Poise" is simply the art of being outwardly calm and steady when perhaps a tempest rages within. This art is cultivated only by those who come daily in contact with their fellow men.

If the office nurse, in this strenuous life she leads, would make sure of living a life rather than simply making a living, she must be something of a humorist, a psychologist, and a philosopher. No human being in any walk of life is more in need of a sense of humor than is a nurse. John Gay, an early English dramatist, wrote his own epitaph, publishing to the world these sentiments: "Life's a jest and all things show it: I thought so once, but now I know it." The nurse should not swing to this extreme, but she should be able to see the funny side of every situation that confronts her. Humor is the safety valve which prevents many an explosion.

It is important also that she be something of a psychologist. Knowing human nature and the workings of the human mind leads to an intelligent and sympathetic understanding of many acts and many symptoms. Last of all she must be a philosopher—a lover of wisdom. Constant searching after the truth and constant evidence of love for those whom she serves will make her world a stage teeming with dramatic scenes. There will be hosts of friends to greet her at every turn and her life will be worth living. Since changed conditions have made the office nurse a necessity, we feel that an increasing number of nurses will seek this attractive field.

Wild Geese

Beauty is coming north again
Slanting eager as the rain;
With necks like arrows on a bow
Across the sky the wild geese go.

Beauty is coming moulded by
High winds of the upper sky
Into shapes that burn to be
In a patterned symmetry.

* * * *

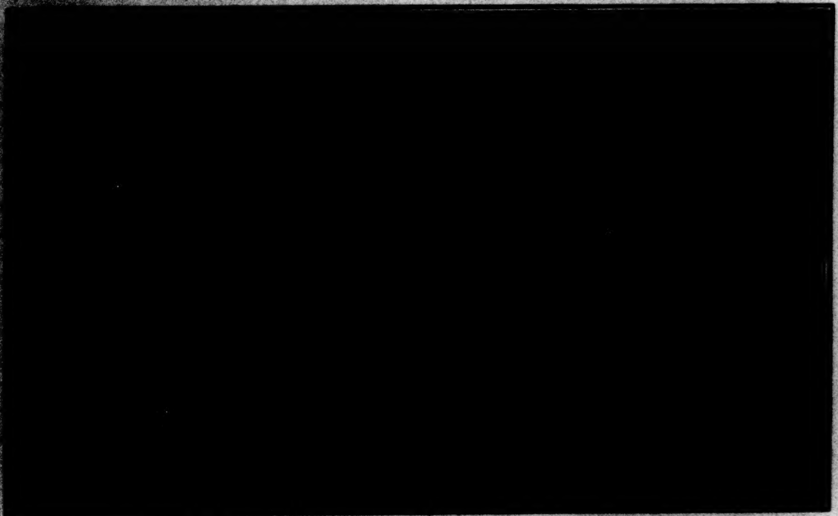
Keen and clean as young desire,
Straight as tongues of evening fire,
Beauty is coming welded bright
From the anvil of Spring's might.

From *Golden Falcon*, by Robert P. Tristram Coffin, published by The Macmillan Company.

The Maude J. Silver Library

MAUDE J. SILVER, Director of Christ Hospital School of Nursing, Cincinnati, died in the very midst of a building campaign which has since brought to fruition some of her most cherished plans for the school. On November 19, 1929, the Memorial Library shown herewith, and which is a part of the handsome new colonial style residence for nurses, was dedicated to her, as an expression of appreciation and gratitude for her untiring efforts during the campaign and for the services she rendered the hospital and school during her years of service on the arduous road from student to principal. The unveiling of a picture of Miss Silver, an exceedingly modest person, who was possessed of rare grace and serenity, by Alice P. Thatcher, Superintendent of the hospital, was an occasion long to be remembered by those who attended the ceremony.

The Library is a worthy memorial and one which will be enriched, in the passing of the years, by further gifts from the alumnae. The room, with its green and copper color scheme carried out in handsome tapestry and soft toned carpeting, with its comfortable furnishings and excellent lighting, possesses dignity and charm.



MAUDE SILVER LIBRARY, CHRIST HOSPITAL, CINCINNATI, O.

The spirit of one who loved books and who eagerly sought knowledge is suitably enshrined. A devoted alumnae will help to carry on the educational work to which she gave her life.

"*Books are not absolutely dead things, but do contain a potency of life in them to be as active as that soul was whose progeny they are; nay they do preserve, as in a vial, the purest efficacy, an extraction of the living intellect that bred them.*"
—Milton, "Areopagitica."

Case Study

A Restatement of the Values of the Case Study Method as Used in Schools of Nursing

HELEN W. MUNSON, R.N.

CASE study as a method of teaching nursing is growing apace. The first reference to it in the *Journal* appeared as recently as 1924 and in that year only one study was published. Since then it has gained space both in the *Journal* and in the minds of thoughtful teachers and during the past year nursing literature has been enriched by the addition of *A Compilation of Students' Records Required for the Course in Pediatric Nursing*, prepared by the staff of the Yale School of Nursing, and of the *Students' Handbook in Nursing Case Studies*, which was developed at the University of Minnesota School of Nursing by Deborah MacLurg Jensen.

Case study is not new. It has long been accepted as a method in other fields of education. Nurses however should be interested in the following from Miss Nightingale's *Course for All Probationers* which outlines the plan for the first modern school of nursing established in St. Thomas' Hospital in 1860: "To take careful notes of cases a case paper should be regularly kept by every probationer of cases selected by the medical instructor."

Before discussing values a restatement of what the case study method includes is necessary in order that there may not be confusion of terms. Teaching nursing by the case study method means assignment to each student in each service or, better still, selection by the student, under guidance, of certain patients for individual and intensive study. This requires the assembling by her, *as the case progresses*, of such information as the recent or remote factors which led to the present illness, the tests and examinations necessary for diagnosis and their implications, the details of medical treatment with interpretation of them, the nursing measures which were used and why they were used. Additional reading and conferences with the head nurse will be needed in order to clarify this material. Based on the information that she has collected and on her observation of the patient, the student, early in the course of the illness, must formulate her own problem and plan for helping to restore her patient to health.

In its final written form the case study will include all of this material, selected and arranged, and also her evaluation of the nursing plan and the way in which she carried it out. It will also contain her own criticism of her work and a statement of what remains to be done. Surely no student nurse could emerge from such a study without a much better conception of what nursing is.

The ultimate aim of the case study method is to improve the nursing care of the patient. Does it? Setting aside method for the moment, what are some of its practical values?

First of all intensive study of the patient and his illness by the student nurse who is caring for him must go far toward helping her to regard him as an individual. At once, on entering into all that is involved in the study, she must come to see that patient as a person, as a member of a family, group, or community, with hopes and fears and wishes. It should be impossible any longer for

her to think of him as a name on the "specimen list" or the "bath list" or as a bed to be made.

Embarked on the study, the student nurse must rather quickly learn to make use of the findings of others. Of course there is the interne's medical history. But Miss Andrews, the social worker, can also throw light upon the marked anxiety which is delaying Mrs. Maloney's thyroidectomy. She knows about the two half-grown children who are running wild at home while Mrs. Maloney is in the hospital. After discovering this fact, and also later after learning how Miss Andrews arranged for the care of the children by a neighbor, who could fail to appreciate the share which others are taking in restoring Mrs. Maloney to health? Again there are the laboratory reports to be eagerly waited for, since so much depends upon the last basal metabolism rate, blood culture, urinalysis, x-ray, or what not. It should not take her long to discover which medical and scientific books are best for her purpose and that medical and nursing journals have a surprising way of publishing up-to-date material which she needs and uses.

But, since time is sometimes limited, the student nurse must learn too to choose rather carefully in her reading and investigation, and to discard quickly that which is not useful to her, or else the patient may be up and away and the study lost in a maze of unguided and irrelevant reading.

Nursing measures should be more readily understood when they are considered in relation to definite diseases or conditions. A review of the anatomy and pathology involved in cirrhosis of the liver should explain the accumulation of fluid in Mrs. Kelly's abdomen. After assisting with a paracentesis in which 4,500 cc. of fluid were withdrawn, the student should have greater appreciation of the order limiting fluid intake to 1,000 cc. She should see that it will be easier, as well as safer, to plan a schedule of the amounts of fluid allowed at stated hours. It should also be easier to teach Mrs. Kelly to respect the order, since she herself understands its importance. It is more interesting now to measure and record carefully the amount of Mrs. Kelly's urinary output and to compare it with her fluid intake and, after diuretics have been ordered, to watch the decrease of abdominal fluid as urinary output is increased. And because the student has learned these nursing measures in relation to definite conditions, she should realize what to expect when she sees these conditions again and should approach them with knowledge and intelligence.

The student nurse should learn that she has a teaching function. There is Nancy, the soiled, badly nourished little waif who on admission required three baths and numerous larkspur caps before she was presentable and who looked with distaste upon the simple foods brought her. After transforming Nancy into the charming, plump, pink and white child who took her own bath daily and who wrote back to her nurse with evident pride some time after leaving the hospital, "My head is all right," should this student not see that nursing also includes teaching?

The student should begin to have a preventive and public health point of view. Alice, ten years old, is dying of a cardiac condition. No one can do anything for her except try to make her comfortable. But what student nurse, after going over Alice's history, could fail to see in her the victim of neglect and that if Alice's mother had known about nutrition, about means for preventing "childhood diseases,"

about having diseased teeth and tonsils cared for, perhaps Alice need not have died? Over across the hall Miss Franks has typhoid. What a waste of time and money! And how easily each could have been saved if Miss Franks had had typhoid vaccine before going on vacation, and if the town fathers in the mountain village where she spent it had looked to their water supply. Who could fail to see the importance of preventive measures in cases like these and to be a step further toward appreciating health nursing as well as sick nursing?

Merely recording cases is of little value unless the student sees in them problems for herself to solve. It may be to plan a 4,000 calorie diet so that it makes no more in bulk than an ordinary diet; it may be to invent devices for the comfort of Mary, who has great furuncles over her body; or to change the mental attitude of one patient in the ward who is on the defensive with all the others because of racial differences; or to help another to combat an increasing desire for narcotics. But if the student analyses each situation to see where she fits into it and plans and carries out her share in solving each problem, not only must her case studies become realities to her but she must begin to think of the care of all of her patients in terms of problems.

Case study should give the student an opportunity for self-criticism, for reviewing her own work and for judging what was good in it and what might have been improved. The case study method should be an economical one for the learner, because the knowledge gained is organized and related. It should be economical for the teacher, because by using it as a basis for regulating and evaluating student experience it should be possible to avoid omissions and repetitions.

Without doubt there are limitations in the present use of this method in schools of nursing. There is some evidence to show that at times emphasis is placed on method rather than on that which use of the method might achieve. Again the health problems of the patient do not always end when he leaves the hospital and the student cannot see them through to their solution. Neither can she be given the main responsibility for planning the nursing care of a given patient.

Public health nursing organizations use case study to teach new staff members how to think through family problems. Is this because graduate nurses come to them unprepared to handle the cases for which they must be responsible? And if this is true, will more general use of the method by schools of nursing obviate the difficulty in the course of time? Or do public health nursing organizations use the method because they find in it a tool useful for their purposes? Older staff members in some public health nursing organizations use it in planning for difficult cases. A statement of the use of the case study method in public health nursing organizations, which includes aims and values as well as methods, would be exceedingly helpful to teachers and students in schools of nursing. Such a statement is now in preparation by Ellen Buell, Educational Director, Henry Street Visiting Nurse Association, New York City, and will appear in an early issue of the *Journal*.

Device for Showing Distribution of Nurses

MARIE V. WANZECK, R.N.

A SIMPLE method of showing the distribution of nurses is pictured above. All that is required is a board of soft wood, shellacked, colored cardboard, and map tacks.

We have used orange cardboard to make the ward headings, typing the name and ward capacity thereon. White cardboard is used for graduates on general duty; pale blue for postgraduate students; lemon for affiliating students; salmon for graduate senior students; yellow for third-year students; blue for second-year students; and green for first-year students.

The section of the class to which the student belongs is typed at the right of the name. When a student is assigned to a certain ward the date, in pencil, is put in the upper right-hand corner of the card. If she has had any previous time on said ward, that is indicated, in pencil, in the lower right-hand corner. If she goes on night duty the date, in pencil, is put in the upper left-hand corner of the card.

About one inch below the regular ward line-up, we have placed the dispensary (part-time) nurses; and on the private floors, the diet nurses are so placed. Below these, about an inch, are the night nurses. A different colored map tack is used to further distinguish those on night duty. In the psychiatric clinic, pediatric department, and obstetrical unit, we simply use the map tacks to distinguish the night nurses, for the supervisors in those units make their own night duty changes, reporting the same to the nursing school office.

One can see at a glance just how many students of each class are on duty on any particular ward, a feature very desirable from a great many standpoints.

Suggestive Plans for Specials

HIGH cost to the patient! Long hours for the nurse! These perennial topics are discussed wherever nurses and patients are. Slowly and painstakingly, one institution after another undertakes experimental plans, in the hope of finding an answer to the problems of both groups.

The following analysis of the problem, made available to the *Journal* by District 18 of the California State Nurses' Association, was adopted by the Seaside Hospital, Long Beach, California, as a basis for experiment this year. It may prove suggestive to other groups. *This plan gives the patient the services of a graduate nurse, but, obviously, not always the entire time of a graduate nurse.* The problem can never be satisfactorily solved without due consideration of the patient, the nurse and the hospital. Each must appreciate the problems of the others. The goal must be, and is, *good* nursing for patients. —EDITOR.

The suggested plan is for nurses on 8-hour duty to rotate thus: 7 a.m. to 3 p.m.; 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m.

After the third day, the average patient could dispense with one nurse, preferably the one on duty from 11 p.m. to 7 a.m.

CASES COMPARED, ASSUMING 12-HOUR AND 8-HOUR DUTY, FOR 14 DAYS

Case No. I. Nurses on 12-hour duty; at $6 per day; 1 patient; illness, 14 days.

3 days (3 × 24 = 72 hours special nursing), 2 nurses at $6 = $12.00 per day
Meals at $2.50 = 2.50
Total, per day $14.50 — 3 days = $43.50

11 days (11 × 12 = 132 hours special nursing), 1 nurse at $6 = $6.00 per day
Meals at $1.50 = 1.50
Total, per day $7.50 — 11 days = $82.50

14 days, or 336 hours, with 204 hours special nursing care, costing $126.00
(The hospital supplies the remaining 132 hours.)

Case No. II. Nurses on 8-hour duty; at $6 per day and no meals; 1 patient; illness, 14 days.
3 days (3 × 24 = 72 hours special nursing), 3 nurses at $6 = $18 per day; 3 days = $54.00
11 days (11 × 16 = 176 hours special nursing), 2 nurses at $6 = $12 per day; 11 days = 132.00

14 days, or 336 hours, with 248 hours special nursing care, costing $186.00
(The hospital supplies the other 88 hours.)

Case No. III. Nurses on 8-hour duty; at $7 per day and no meals; 2 patients; illness, 14 days.
3 days (3 × 24 = 72 hours special nursing), 3 nurses at $7 = $21 per day;
3 days = $63.00
One-half of that = $31.50

11 days (11 × 16 = 176 hours special nursing), 2 nurses at $7 = $14 per day;
11 days = 154.00
One-half of that = 77.00

14 days, or 336 hours, with 248 hours special nursing care, costing $108.50
(The hospital supplies the other 88 hours.)
(NOTE.—This patient actually gets one-half of 248, or 124 hours nursing care.)

PLANS COMPARED, ON BASIS OF A SINGLE DAY WITH CONSTANT SPECIAL NURSING

Present system:

1 patient, 2 nurses, on 12-hour duty, making 24 hours care, at $6 per day and meals.
Cost to patient per day, including meals of nurse, $14.50.

Suggested plans:

Plan 1

1 patient, 3 nurses, on 8-hour duty, making 24 hours care, at $6 per day, no meals.
Cost to patient per day, meals of nurses not included, $18.

Plan 2

2 patients, 3 nurses, on 8-hour duty, making 24 hours care, at $7 per day, no meals.
Cost to each patient per day, meals of nurses not included, $10.50. (NOTE.—He gets one-half the care.)

POSSIBLE COMBINATIONS OF SUGGESTED PLANS 1 AND 2

Combination No. 1. 1 patient, 14 days of illness.

First 3 days; 1 patient; 3 nurses at $6 per day; 8-hour duty		
3 days special care at $18 per day		$54.00
3 × 24 hours = special care for	72 hours	
Next 7 days; 1 patient; 2 nurses at $6 per day; 8-hour duty		
7 days special care at $12 per day		84.00
7 × 16 hours = special care for	112 hours	
Next 4 days; 1 patient; 1 nurse at $6 per day; 8-hour duty		
4 days special care at $6 per day		24.00
4 × 8 hours = special care for	32 hours	
14 days (336 hours) this patient has special care for	216 hours	$162.00
(The hospital supplies the other 120 hours of care.)		

Combination No. 2. 2 patients, 14 days of illness.

First 7 days; 2 patients; 3 nurses at $7 per day; 8-hour duty		
7 days special care at $21 per day		$147.00
7 × 24 hours = special care for	168 hours	
Next 7 days; 2 patients; 2 nurses at $7 per day; 8-hour duty		
7 days special care at $14 per day		98.00
7 × 16 hours = special care for	112 hours	
14 days (336 hours) these patients have special care	280 hours	$245.00
Each patient gets one half this care at cost of		$122.50
(The hospital supplies the other 56 hours of care.)		

Combination No. 3. 1 and then 2 patients, 14 days of illness.

First 7 days; 1 patient; 3 nurses at $6 per day; 8-hour duty		
7 days special care at $18 per day		$126.00
7 × 24 hours = special care for	168 hours	
Next 7 days; 2 patients; 3 nurses at $7 per day; 8-hour duty		
7 days special care at $21 per day = $147: for each		73.50
7 × 24 hours = special care for	168 hours	
14 days (336 hours) this patient has special care for	336 hours	$199.50
(During the second week each receives one half the total number of hours.)		

This plan, if the patients' condition would permit, could be changed in the second week of care to:

2 patients; 2 nurses at $7 per day; 8-hour duty.

7 days special care at $14 per day = $98: for each, $49.

This reduces the total cost to $175 with the special care in the second seven days reduced to 112 hours (of which each patient gets one half) and the hospital gives 56 hours care.

These plans can be changed to fill the various needs of the patient, as his condition permits. They involve important administrative problems.

[illegible]

Tabulated Cost to Patient for Two Weeks Special Care, Giving Hours of Special Care and Hospital Care

	Cost to Patient for 14 Days Special Care	No. of Hours Special Care	No. of Hours Hospital Care	Financial Saving to Patient Over Present System
Present system at $14.50 per day..............	$203.00	336	0	
Combination				
No. 1.........	162.00	216	120	$41.00
No. 2.........	122.50	280 (shared)	56	80.50
No. 3.........	199.50	336 "	0	3.50
alternate No. 3.........	175.00	280 "	56	28.00
No. 4......... (See Case III)	108.50	248 "	88	94.50

Measles

PERMANENT immunization of children against measles by the use of their parents' blood has been found so successful in this city that physicians are to be advised as to the method of drawing the adult blood and injecting it into children exposed to measles. This is expected to be a heavy measles year, and much stress is being placed on the efficacy of the comparatively new whole blood injection treatment, which has withstood the most rigorous tests in a study covering ten years. Since the use of whole blood of adults was brought to the fore in Germany, in 1920, Dr. William H. Park and his associates in the Department of Health in New York have studied it closely, and because of its great immunization qualities this method is now strongly advocated by the Health Commissioner for general adoption.

Although the use of serum from convalescent cases of measles has been quite general and successful for some years, it has always been difficult to obtain it in sufficient quantities.

The use of the adult blood makes it much easier for the physician, for the reason that it can be obtained right in the home of the patient and coming directly from the parents there are absolutely no deleterious effects.

The blood is taken from either the father or the mother of the child, from the vein just above the elbow of either arm. A syringe holding one ounce is used, and when the blood is withdrawn half of it is injected into the muscles in the right buttock of the child and the other half in the left. If there is to be any delay in the use of the blood a small quantity of a sterile solution of sodium citrate is used in the syringe to prevent the clotting of the blood.

Dr. Alfred Hess, who aided in the studies and tests, recently used the serum and the whole blood treatment in an institution, giving one group of the exposed children the adult blood and the other portion convalescents' serum. The children receiving the latter developed fewer cases of measles, but those who were given the whole blood of adults had modified cases. The latter outcome is really preferable, because those in whom measles was absolutely prevented developed no lasting immunity, and after one month were again liable to contract the malady, while those who had modified or mild attacks were rendered immune to measles for life.

The use of the blood of parents in combatting measles will, in some measure, aid the city in solving the very important problem of preventing measles, but its greatest value is in saving life. Now the blood can be obtained right in the home of the child, and we believe the way is opened not only to reduce the measles death rate, but to render more children immune to the disease each year.—Abstract from a release from *The Health Commissioner of New York*, February 9, 1930.

Some Specialists

Mary Breckinridge, R.N.

Nurse-Midwife

IN a very true sense, Mary Breckinridge is a specialist. A fifth generation Kentuckian, her entire professional preparation has been motivated by one thought—the need of the dwellers in the Appalachian mountain range, 250,000 of whom live in her state, for nursing care. Marriage followed her graduation from St. Luke's Hospital School of Nursing in New York City, and the loss of two children, under conditions which would not have prevailed in a large city, strengthened her resolve. Training in public health nursing was secured under the able leadership of Anne Strong and Mary Beard, in Boston.

Mrs. Mary Breckinridge

The Great War and its aftermath absorbed all her energies for a time during which she organised the Visiting Nurse Service of the American Committee for Devastated France, under Miss Morgan and Mrs. Dike, and was Director of Child Hygiene and Public Health Nursing for that committee, 1919–1922.

This was followed by a year's study of public health nursing at Teachers College, New York. Then, working in coöperation with Dr. Arthur McCormack, State Health Officer for Kentucky, and travelling on horseback, she made a careful study of obstetric conditions in three mountain counties, with an area of 1,000 square miles and a population just under 30,000. She found that, in the preceding year, 968 births had been reported for this territory, and that reported deliveries had been made by nine doctors, not all of whom were state-licensed, and 128 midwives. Twenty other midwives had not reported their cases. Since the average age of fifty-three of the midwives, who were personally interviewed, was 60.3, it was obvious that this could not be considered a teachable group.

The conclusions drawn from the study were:

(1) Persons attempting to serve the

group must be so situated that they would be available within reasonable time, hence a decentralized service was needed.

(2) The existing supply of doctors, especially if limited to those holding the state license, was entirely inadequate.

(3) The number of midwives could be reduced three-fourths if young and well mounted.

(4) Because of the way babies have of coming in clumps, two attendants would be necessary for each unit of space to be covered, and not all of their time would be needed for mid wifery.

Out of these conclusions came a decision to go to England to study midwifery, since no course for nurse-midwives was available in this country. Mrs. Breckinridge secured the necessary training at the British Hospital for Mothers and Babies in London, and rounded out the experience by securing the certificate of the Central Midwives Board. After careful observation of the medical and nursing service established by Sir Leslie McKenzie in the highlands and islands of Scotland, Mrs. Breckinridge was ready for her self-appointed task. The Frontier Nursing Service, one of the most appealing and dramatic health services in this country, is the incarnation of her dreams. Single-handed, Mrs. Breckinridge has organized committees in various cities which have pledged themselves to support the work. Year by year, the work grows as Center after Center is established. It now covers 500 square miles with over 5,000 patients of every variety from the desperately ill to those who are carried for health work only. One of the Centers has an eighteen-bed hospital with a subsidized staff of physicians. As the work grows it is planned to make every seventh or eighth nursing center a hospital providing medical care.

Eighteen of the twenty nurses now employed have prepared for midwifery and have taken the Central Midwives Board examination in England. They live at the Centers in the heart of their mountain territories, each of which has approximately a five-mile radius. It is difficult to get even five miles on horseback over rough trails and swollen streams on stormy winter nights with any speed and some of their exploits are nothing short of heroic. About one-fourth of their time is devoted to maternity work, one-fourth to other bedside nursing, one-fourth to infant and preschool hygiene, while public health work, including inoculation against disease, hookworm, trachoma, and school hygiene, fully occupy the remainder.

Possessed of initiative, courage, energy, vivid personality, Mrs. Breckinridge recognizes also the value of preparation and training. By becoming a specialist herself, she attracts an extraordinarily fine group of women, who endure many hardships and isolation, in order to promote the ever expanding health program planned by a dynamic leader for Americans of fine stock and splendid potentialities.

Editorials

Over the Top for Grading

RHODE ISLAND may be small, but her people are mighty when they decide to reach a goal. It was an alumnae association in that state which wrote to a national officer, "Two years ago you advised us to do five things. They have been done!" And the writer went on to tell of new plans and aspirations. It was in the same spirit that Rhode Island set about completing its quota for financing grading, with the result that although its quota, like that of all the other states, was $1.57, the state has subscribed $2.27 per capita to date.

Twelve other states have either pledged or paid the quota in full. It is a magnificent record. What thirteen states have done the others will do. Immersed always in urgent affairs, it is not at all surprising that the officers of some of the states have not realized how quickly the five-year span of life of the Grading Committee is passing. Actually, however, the fund must be completed by June, 1931, in order to assure the effective functioning of the Committee's office staff during the highly important closing months of the study. With the figures before them, as in one state where two districts are "over the top" and the others coming along, it is almost a foregone conclusion that each state will at once complete its plans for raising funds. Each one will want to participate in the satisfaction at Milwaukee of hearing an announcement by the Nurses' Committee on Financing Grading something like this: "Thanks to the splendid work of the states, the Committee turns in a report of 100 per cent subscribed."

The Committee on Grading Nursing Schools has brought, and doubtless will continue to bring, economic and other problems out of sensitive obscurity into the wholesome light of day. It is putting the facts into forms that will be usable by groups other than nurses. Boards of hospital trustees, doctors, the nurse-employing public, are being influenced by the results of the Committee's researches as they never would have been by the statements of nurses. Slowly but surely, some of the facts are altering and expanding the thinking of nurses themselves and of those who think about nurses. Many of both groups have assumed that they were thinking when they were only "rearranging their prejudices." Some have labored under the delusion that affirming a prejudice indicated thought. However its contribution may finally be evaluated, there will be none to gainsay the statement that the work of the Committee on Grading Schools of Nursing caused nurses and those connected with them to think with greater precision than before. The development of nursing in the future will inevitably be influenced by the findings.

It is *our* profession which is being studied, our profession which will develop more spaciously because of the study and, because it is ours, right loyally and triumphantly we shall proceed to complete our quotas in order that the Committee may be unhampered by lack of funds.

Magazines Not To Be Combined

AS announced in our news pages, the *Public Health Nurse* and the *American Journal of Nursing* are not to be combined. The editors of both magazines believe the decision is sound. This will disappoint those persons who had hoped for a combination of the two magazines at approximately the price of one and those who had hoped to find, between the covers of one magazine, all of our periodical professional literature. Careful study has shown these objectives to be impossible of attainment. Since 1926 a joint committee has been at work on the problem, first suggested by the National Organization for Public Health Nursing, of combining or amalgamating the two national nursing magazines. The committee and its subcommittee have worked faithfully and arduously, beginning with an analysis of the field to be covered and ending with the decision stated above, which has been accepted by the Joint Boards of the national nursing organizations.

The analysis of the field to be covered fills fourteen typewritten pages! With this in hand the subcommittee began the task of studying ways and means of combining the material without loss of interest or material to any group and of producing a new magazine covering the whole field of nursing, if possible at the price of one of the existing magazines. It simply couldn't be done. The mere addition of the material in one magazine to that in the other would produce a magazine too bulky for convenience. Any method of dividing the material implied the production of two new magazines or of one magazine and numerous bulletins. In other words, nurses now reading both magazines, by any plan suggested, would still have more than one publication to keep up with. Furthermore, no method of making any considerable reduction to the individual nurse in the cost of professional publications could be found.

When it became clear that neither of the two desired objectives could be reached, namely, a reduction in cost to readers of both magazines, and combination of material without loss of scope, the decision was reached that the two magazines should be continued. The time spent in this study has by no means been wasted. Each magazine has a clearer conception of its own function than ever before. Each is working whole-heartedly with the other in an effort to serve the whole field and to avoid duplication of material, of costs and of effort. An informal editorial council, composed of the editors at Headquarters, will tend steadily to enlarge the editors' vision of functions. The editors of both magazines rejoice that the moot question has finally been constructively settled.

Wanted—New Style Articles

"BY their fruits ye shall know them." Many private duty nurses have had patients rise up and call them blessed, but the fact is not advertised to either public or profession. The doctor, the family, a few friends of the patient, know the quality of her service, the esteem, even the affection the family feels for the individual. Perhaps the good news reaches the registrar, perhaps not. Of course it should. That is one of the points in the administration of registries that is receiving considerable thought at the present time.

Time was—and that not so long ago—when a considerable part of our professional literature was made up of articles on "Thou Shalt"—or "Thou Shalt Not." That era is rapidly

passing and administrators, teachers, public health nurses, anesthetists, office nurses and others are telling *how* they do their work. This makes it possible for them to compare methods, to study results, to adopt new methods when they have been shown to be desirable. This is all quite in line with sound professional development. Scientists do not consider that discoveries have permanent value until the results have been published and tested by others working in the same field.

Private duty nurses are still in the Do and Do Not stage of their development. This is partly due to the fact that, owing to the considerable number of unworthy persons hanging on to the fringes of that specialty, private duty nurses are still writing "defense" articles. It is time for private duty nurses to face this issue squarely. The well informed know that there are many fine nurses in the private duty group. Mere affirmation will never prove this to the uninformed, especially if they have had unhappy experiences with those on the borders, as it were, of the group.

It is time, high time, that private duty nurses began writing of *how* they nurse. It is many years since Miss DeWitt and Mrs. Lounsbery wrote their books on Private Duty Nursing. It is incredible that no new authors have arisen in that field. There is serious need for an augmented body of professional literature on private duty to which all nurses could point with pride and say: But *that* is what we mean by private duty. Good articles on the adjustments private duty nurses make to the constantly varying situations they meet, on improvisations in homes, on the diversion of bored or weary patients, on the actual nursing technics employed, on health teaching in homes, would be welcomed with joy in the *Journal* office.

Until private duty nurses write of their achievements in terms of nursing care, they will continue to run the risk of serious misunderstanding by members of their own profession. "By their fruits ye shall know them." Who will be the first to send in an article on the art of nursing as practiced in private duty? What a contribution it would be if nurses would begin writing on such subjects as, "How I Nursed a Series of Ten Appendectomy Cases, The Nursing of Five Patients with Pneumonia, or Three Intestinal Carcinomas."

Private duty nurses are suffering from an inferiority complex. Here is a way to cure it. Who will make the first effort toward cure? Who will take seriously the reminder that "By their fruits ye shall know them" in order that those who see may believe?

The Census

IF you are a registered nurse be *very sure* that you are so listed by the census taker! This is important. If you have read all the way through the article "Uncle Sam Wants to Know," on page 283, which was prepared in the Census Bureau, you will have discovered this for yourself, but many people read only a few paragraphs of an article and this statement does not appear, as we believe it should have, in the opening paragraphs.

To assure this, tell any person who is liable to be in the position of having to answer for you exactly what kind of a nurse you are and the exact nature of your employment.

Our Contributors

When Carrie M. Hall, R.N., completed her service as President of the National League of Nursing Education, it might have been expected that she would "rest awhile" from arduous professional labors. Not so! As Chairman of the Joint Committee to Finance Grading, as a nurse representative on the Board of the Harmon Association, and as Chairman of the American Nurses' Association's Relief Fund, she has labored diligently and sympathetically to solve some of the intricate economic problems of the profession.

Dr. A. V. de Neveu, Medical Director of the Johnston Emergency Hospital, Milwaukee, has given us a timely article, since the death rate from automobile accidents alone has risen from 15.7 per 100,000 population, in 1924, to 20.8 in 1928.

Charlotte C. Crossley, R.N. (North Chicago Hospital School of Nursing) is Surgical Supervisor and Instructor in Surgical Nursing in the school of the City Hospital, Cleveland, Ohio.

The editors will welcome illustrations and data for other coöperative nursing procedures articles, and hope to arouse a very active interest among nurses in finding out not only *how* but *why* a given method is used.

Dr. Marion Craig Potter has striven to make her article on gonorrhea as concise and practical as possible by limiting her discussion to essentials.

Everdeen Harmeling Johnson, R.N. (Presbyterian Hospital School of Nursing, Chicago) has had special training for the rural public health nursing she finds so intriguing.

Esther M. Stone, M.D., is Senior Physician at the Peoria State Hospital, Peoria, Ill.

After active service as a private duty nurse, Cava Wilson, R. N., has recently become superintendent of the Pines Sanatorium in Shreveport, La.

Elizabeth Sheppard Mildner, Assistant Docent of the Brooklyn Museum, has been deeply interested in the classes of student nurses from near-by schools.

The article "What Kind of a Nurse Are You?" is a direct challenge. Be sure that the census enumerator secures exact data, especially if you are a *registered* nurse. Before another general census is taken, it is to be hoped that a clearer classification may be made by the Census Bureau.

After some years on the faculty of her alma mater, and postgraduate work at Teachers College, New York, Eugenia Kennedy, R.N. (St. Vincent's Hospital School of Nursing, Indianapolis) became Educational Director and Executive Secretary of the Indiana State Nurses' Association. During her hospital years, she was a member of the committee of the Indianapolis Official Registry, which maintains unusually close and harmonious relations with individual nurses.

During a prolonged visit in Italy, Alice Fitzgerald, R.N. (Johns Hopkins Hospital School of Nursing), and internationalist of wide understanding and sympathy, made the careful study of Italian nursing on which her article is based.

Grace H. Cameron, R.N., now retired from active nursing, was at one time a member of the New York Board of Nurse Examiners, and for a number of years was Review Editor for the *Journal*.

Since the duties of office nurses must necessarily be closely related to the practice of the particular physician or group of physicians, it would be difficult to outline a pattern which would fit all situations. The article by Anne P. Martin, R.N., is constructively suggestive, even though few may agree that office nursing should be included in the undergraduate curriculum.

We are indebted to Nell Falgner, R.N. (Good Samaritan Hospital, Cincinnati), Publicity Secretary of District Four, Ohio State Association, for data on the Maude J. Silver Memorial Library.

Marie V. Wasseck, R.N., B.A. (University of Michigan and Johns Hopkins Hospital School of Nursing) has been Assistant Director of the University of Michigan School of Nursing and Assistant Superintendent of the Johns Hopkins Hospital School.

Pearl I. Castile, R.N., M.A. (see Eminent Teachers, August, 1929) made her study of normal children as part of the work toward a Master's degree at the University of California.

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY NINA D. GAGE, M.A., R.N.

Contribution to the Education of Nurses Made by a Study of Normal Children[1]

PEARL CASTILE, R.N.

NURSING education is in the transition period between the apprenticeship method of training and professional education. Standards of classroom instruction and perfection of technic have been emphasized during this period with a consequent lessening of appreciation of the values in learning at the bedside of the patient. Not least among these values is the inevitable interest on the part of the student in the patient as a human being.

It has been, and still is, the practice in nursing school classrooms to teach the student disconnected procedures used in nursing, such as making a bed with a patient in it, giving a bath to a patient in bed, etc. If all the procedures relating to the daily nursing of the patient were integrated in one large unit, the student would think in terms of the complete nursing care. Under the present system she is taught procedures. Therefore she tends to carry out procedures.

This tendency in teaching has been strengthened and encouraged in many hospitals by the necessity for getting the work done with a minimum staff of workers. As a result, a system of "piecework" has been established in which one nurse takes the temperatures of all the patients in the ward, another gives all the medicines, still another may do all the dressings and treatments.

This specialization is open to the gravest objections—it gives instead of a total clinical picture of the disease or condition treated, only a fragmentary and even misleading knowledge of the single duty performed.

Thus the senior as "dressing-room nurse" gains indeed a large experience of wounds and surgical dressings, but without opportunity to relate them to the general condition of the patient. In effect, she is taught to treat the wound rather than the patient. But, unfortunately, the complexity of the human organism does not lend itself to such subdivision, and the nurse, who is ultimately to be responsible for specific patients, will find herself confronted with conditions which she has never been taught to meet. On the wards she has given only routine nursing care; as "dressing-room nurse," she has learned surgical treatments; never in her training, either on the wards or in the dressing room, has she been taught to care for the surgical patient as a whole; to watch for and recognize later effects of treatment, the entire human reaction.

The exceptional nurse may indeed, by virtue of unusual memory and imagination, combine her various experiences so as to draw for herself a total clinical picture and gain an intelligent understanding of the whole case. As a system of instruction, such an extreme of specialization needs only to be described to be condemned.[2]

[1] This study was made under the supervision of Dr. Edna Bailey, Professor Mary May [illegible] and Dr. Herbert Stolz, and was submitted in partial satisfaction of the requirements for the degree of Master of Arts in Education in the Graduate Division of the University of California.

[2] *The Committee for the Study of Nursing Education*, 1923, page 305.

Furthermore, the entire educational program has aimed to give a knowledge of how to care for abnormal conditions caused by disease.

Even in the care of children, where today the prevention of sickness through proper feeding, hygiene, and the creation of right habits is beginning to make headway, the teaching of the nurse still remains almost wholly instruction in the diseases of childhood.

This limitation, typical of her whole curriculum, is one of the most serious handicaps in the training of the nurse. For nurses, preeminently those in public health work, are to be engaged primarily in the prevention of sickness; nay more, they are to have the more difficult office of teaching the prevention of sickness in people's homes. This is, as we have seen, their special function. It is, therefore, of the first importance not only that they should be equipped to recognize symptoms of disease and learn methods of cure, but that they should be better equipped to recognize symptoms and conditions antecedent to disease and learn the means of combating these before disease appears. It is, then, surely an anomaly that their training should deal so largely with cure alone. This stress upon the now well established principles of hygiene and prevention is perhaps the cardinal need in the nurse's didactic instruction.[3]

This study is an attempt to determine whether a knowledge of normal children will give the student an appreciation of the total personality of the child and thus improve the quality of nursing care given to sick children. It is a record of an experiment conducted by the writer in a course in pediatric nursing given to senior students in the Highland School of Nursing, Oakland, California. Opportunity was provided for the students to study the normal child through formal classroom instruction and through actual observation of children. By means of close supervision of these students while nursing sick children in the Highland Hospital, an attempt was made to evaluate the influence of these experiences on the quality of nursing service.

[3] *The Committee for the Study of Nursing Education*, 1923, page 369.

The primary objectives of this paper are (1) to describe a plan by which a study of normal children can be provided for students of nursing; and (2) to analyze and, as far as possible, measure the influence of such a study upon the behavior of the nurse.

The material here presented has been collected in conferences with nurse educators, by questionnaires to schools of nursing, from literature, from the content of courses offered to students of nursing, and by experimental teaching of a course "Preventive Pediatrics" with observation of the results of this course.

It is believed that this study, although limited in the number of cases, contains some information relative to the value of providing an opportunity for students of nursing to study normal children.

Questionnaire To Determine Present Courses Offered

To ascertain whether the course in pediatric nursing as offered in schools of nursing provides a study of normal children, the following questionnaire was sent to fourteen of the leading schools of nursing in the United States. Fourteen seems a small number from which to draw conclusions. However, the schools selected were university schools, or those affiliating with universities, and therefore represent those offering the most liberal curricula at the present time. By means of the questionnaire, it was hoped to determine (1) whether any study of the normal child is provided; (2) if provided, what is the content of the course; and (3) what are the values of such a course.

1. In your course in pediatric nursing, do you provide experience with normal children?

Pediatric Department — Communicable Department

Student	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
March 4	E	E								E	E							
" 5																		
" 6																		
" 7			E	E									E	E				
" 8																		
March 11					E	E								E	E			
" 12																		
" 13																		
" 14	N	N								N	N							
" 15							E	E								E	E	
March 18			N	N								N	N					
" 19									E									E
" 20																		
" 21					N	N								N	N			
" 22																		
March 25							N	N								N	N	
" 26	K	K								K	K							
" 27																		
" 28									N									N
" 29			K	K								K	K					
April 1-5 Spring Vacation																		
April 8					K	K								K	K			
" 9																K	K	
" 10							K	K										
" 11																		
" 12									K									K

E - Elementary School K - Kindergarten N - Nursery School

SCHEDULE OF OBSERVATIONS OF NORMAL CHILDREN

2. How is this experience provided? In a nursery? In a clinic?

3. How much time is given to this experience?

4. Does this experience consist in observation or actual care of children?

5. Are there classes or lectures given in connection with the practical experience?

6. Do you use an outline for this course? If so, may I have a copy?

7. Do all students receive this experience or is it elective?

8. Is the course given before the pediatric ward experience?

9. Has the course influenced the attitude of the student toward sick children and has it provided better care of the children?

10. What specific benefits do you feel are derived from the study of normal children for students of nursing?

11. What is the student's reaction to the course?

12. If you do not have a course, would you think it advisable to provide such experience?

Table I indicates the results of this questionnaire.

There is wide variation in the character of the opportunity provided for the experience with normal children in these fourteen schools. Those schools devoting from fifty to ninety-six hours to such study place the students in the nursery school or on the well-baby ward to care for the children. These nurses acquire their knowledge of normal children by observing them as they care for them. The schools providing experience by observation in the well-baby clinic are limited to contact with normal children under two years of age. It is a question whether a clinic provides a situation which favors normal reactions of children. Of the schools giving experience through caring for the children, or by observing them, none, as far as I have been able to determine, has an organised plan of observation of the normal child.

Of the six schools at present offering no opportunity to study normal children, all but one state that such a course should be given and three of these schools are now making plans for such work. One school expects to provide this opportunity through the infant welfare clinic; another, through

TABLE I—PROVISION MADE FOR A STUDY OF NORMAL CHILDREN BY FOURTEEN SCHOOLS OF NURSING

School of Nursing	Hours of Class Instruction	Hours of Practical Experience	Method of Study	Institution Used	Number of Students Receiving Practical Experience
1.	4	50	C	N. S.	All
2.	0	96	C & O	N. S. & W. B. Cl	All
3.	0	Indefinite	C	W. B. Wd	All
4.	5	8–12	O	W. B. Cl	All
5.	2	96	C	W. B. Wd	⅓–½
6.	0	2	O	N. S.	All
7.	6	6	O	W. B. Cl	All
8.	0	8–12	O	W. B. Cl	½
9.	0	0			
10.	0	0			
11.	0	0			
12.	0	0			
13.	0	0			
14.	0	0			

N. S.—Nursery School; W. B. Cl—Well-Baby Clinic; W. B. Wd—Well-Baby Ward; O—Observation; C—Care for Children.

the nursery school; and a third school is planning a course of fifteen hours on the "Normal Child" which will consist largely of the Psychology of Childhood.

A few quotations from the replies to the questionnaire may serve to indicate the opinions of the directors of these schools of nursing as to the need for a more thorough understanding of normal children:

1. It is especially helpful in teaching students how to approach the child.

2. Significance of the abnormalities is understood when compared with normality.

3. A knowledge of normal children is important to a nurse in whatever field of nursing she may enter.

4. Conservation of health is emphasized.

5. Stimulates an interest in public health.

6. A knowledge of mental and physical hygiene of the normal child will help the nurse who has a family in later years.

7. I know many nurses learn to like babies when studying well babies—a big step toward success in pediatric nursing.

Only one of the fourteen schools expressed an opinion that a study of the normal was inadvisable, the reason for this being lack of time in the already too crowded curriculum. Another opinion stated that "Such experience is very advisable providing facilities are near enough."

The Introduction of a Course in the Study of Normal Children

THE next step in this study consisted in planning a course in the "Growth and Development of the Normal Child" which could be given in a school of nursing. Eighteen hours were allotted to lectures and class conferences. The student attended these classes in her hours off duty. Time for observation, approximately twelve hours, was included in the student's eight hours of duty.

Fifteen students were asked to take the course. These were students who were at that time receiving their twelve weeks' practice in pediatric nursing or communicable disease nursing. The pediatric and communicable disease departments were selected because they offer experience with sick children. Here, knowledge could be applied and comparisons could be made to show the effect of this knowledge on the kind and quality of nursing done by the students. It is interesting to note that at least ten additional students asked to be admitted to the class. Three of these were allowed to enroll, making a total of eighteen students. A larger number seemed inadvisable as it would have been impossible to plan time for more observation trips without seriously interfering with the work on the wards. A second group of eighteen students was selected to serve as a control group.

The name "Preventive Pediatrics" indicates the emphasis placed upon normality, conservation of health, and prevention of disease; and also connotes opportunity for comparison of the normal with abnormalities produced by disease.

In order to benefit most from the hours devoted to classwork, conferences, and observations, the following preparations were made before the course started:

1. For the classwork, it was necessary to provide more reference material than the library of Highland School of Nursing offers. To enrich the library, the Alameda County Library kindly loaned to the school for a period of three months, six books: Gesell, A., *Mental Growth of the Pre-school Child*; Terman, L., *Hygiene of the School Child*; Thom, D., *The Mental Health of the Child*; Baldwin, B., *The Young Child;* Baldwin and Stecker, *Psychology of the Pre-school Child;* and Arlitt, A., *Psychology of Infancy and Early Childhood.* In addition, pamphlets were obtained from the Children's Bureau of the United States Department of Labor.

2. As a part of the course, five observations were planned. These were to include the observation of children of the nursery-school

age, kindergarten age, and elementary-school level. In order to appreciate the home environment of children, one home visit was included. In addition to these, one detailed observation of a sick child was made.

Plans for each of these observations were made as follows:

An "Outline of Observation of Children" used at the University of California was made available for the students. Arrangements were made to permit the students to observe at the Child Welfare Institute in Berkeley. Here, the age range of the children is eighteen months to four and one-half years. These observations were made on Monday and Thursday mornings between 10 a.m. and 1 p.m., beginning March 14, 1929. Not more than five students observed at any one time. The child observed was known to the students only by a code number. A summary of the physical, mental and social development of the child was made available to the student after the observation had been made.

Through the courtesy and interest of the Superintendent of Schools, Oakland, California, the students of Highland School of Nursing were permitted to observe children of kindergarten and elementary school ages in two Oakland schools, Glenview and McChesney. These schools were within walking distance of Highland Hospital. The principal of each school was interviewed before sending students to observe, and arrangements were made for selecting the children to be observed and for use of school records. A schedule of observations was given to each principal. A sample of this schedule follows:

GLENVIEW SCHOOL

Observation—Elementary

March 4	Miss L.	Miss W.
March 7	Miss S.	Miss S.
March 11	Miss D.	Miss P.
March 15	Miss T.	Miss K.
March 19		Miss F.

Observation—Kindergarten

March 26	Miss B.	Miss J.
March 29	Miss S.	Miss W.
April 8	Miss C.	Miss S.
April 10	Miss V.	Miss Y.
April 12		Miss F.

It was necessary to plan these observations so that the work of the hospital wards should not be interfered with. Not more than two nurses were taken from a ward at any one time. If the observations could be planned over a longer period of time, the schedule could easily be made so as to remove one student only from a ward at any one time.

For the home visit an outline was made by the writer. The visits were friendly calls upon children who had been former patients, or the parents of children then in the hospital. The Social Service Department of the Highland Hospital gave the students the information in their files concerning these families.

The last observation planned was that of a sick child. The outline for the study of a normal child was used for this.

Standard for Judging the Influence of Course "Preventive Pediatrics"

ONE of the major problems of this study is the question of the value of such a course. To estimate the effect of the course in Preventive Pediatrics, a standard for judging its influence was drawn up.

This rating scale aims to measure the effect of a nurse's knowledge of the reactions of normal children upon the quality of her nursing care. This standard keeps the emphasis on the child, attempting to measure the ability and accomplishment of the student in terms of the care she gives to the child.

STANDARD FOR JUDGING INFLUENCE OF COURSE "PREVENTIVE PEDIATRICS"

During last thirty days, how often have you noted the following?

	Noticeably or Several Times	Once or Twice or to Some Degree	Never
I. *Attitude toward Health of Child*			
A. Restoring Health in Child			
1. Sensitiveness to Patient's Condition			
a. Observation of interests of child			
(1) Has the child been made happier by finding his interest?			
b. Observation of needs of child			
(1) Have rest and quiet been provided when needed?			
(2) Have companions been provided when needed?			
(3) Has the child been left alone when condition so indicated?			
(4) Have treatments been given when needed?			
(5) Has nutrition been neglected?			
c. Observation of deviations from normal			
(1) Have changes been noted in mental attitude or behavior?			
(2) Have changes been noted in physical condition?			
(3) Have changes been noted in social attitude? (Toward doctors, nurses, other children?)			
2. Realization of Importance of Environment			
a. Has the room been properly ventilated?			
b. Has the proper temperature been kept?			
c. Have the surroundings been untidy?			
d. Has the order of the room prevented free play of the child?			
e. Have isolation precautions for protecting child been observed?			
3. Comfort			
a. Observant			
(1) Has discomfort of patient been noted?			
(a) As to position?			
(b) As to clothing?			
(c) As to bedding?			
(d) As to personal cleanliness?			
b. Anticipation of wants and needs			
(1) Have therapeutic treatments been given when needed?			
(2) Has personal hygiene been cared for?			
(a) Has food been given when needed?			
(b) Has water been offered when needed?			
(c) Has elimination been neglected?			
(d) Has proper clothing been provided?			
c. Details			
(1) Has her work been finished?			
(2) Has the quality of her work been foremost in her mind?			
d. Resourcefulness			
(1) Has she considered the individual?			
(2) Has she introduced her own methods of providing comfort?			

Standard for Judging Influence of Course "Preventive Pediatrics"—*Continued*

	Noticeably or Several Times	Once or Twice or to Some Degree	Never
4. Feeding			
a. Patience: Has the child been hurried?			
b. Thoughtfulness: Have the trays been attractive?			
Has the patient been considered when food was selected?			
c. Ingenuity: Have ways been used to induce the child to eat?			
5. Treatments			
a. Kindness			
(1) Has the procedure been adapted to the child?			
(2) Has the child been distracted from unpleasant features of treatment?			
(a) By conversation?			
(b) By stories?			
(c) By other means?			
(3) Has an explanation of treatment been made?			
b. Care			
(1) Has good technic been observed?			
(2) Have evidences of carelessness been observed?			
6. Interest and Effort in Obtaining Information Concerning Patient			
a. Has she read the history?			
b. Has she questioned the patient?			
c. Has she questioned the family and friends?			
d. Has she sought information from doctors?			
e. Has she sought information from supervisors?			
B. Consideration of Interests and Abilities of Child			
1. Use of leisure time			
a. Have books or playthings been provided to the child?			
b. Have stories been told?			
c. Has the time been used constructively?			
2. Judgment			
a. Has judgment been based upon observation of child?			
b. Have visitors been allowed to stay when the physical condition of the child demanded rest and quiet?			
c. Has rest been provided when signs of fatigue appeared?			
d. Has proper type of exercise been provided?			
C. Teaching Health Habits			
1. Have opportunities for teaching health been recognized and used?			
2. Has teaching been done in a desirable way?			
II. *Attitude toward Parents and Friends*			
A. Understanding			
1. Have the anxiety and concern of parents been understood?			

STANDARD FOR JUDGING INFLUENCE OF COURSE "PREVENTIVE PEDIATRICS"—*Continued*

	Noticeably or Several Times	Once or Twice or to Some Degree	Never
B. Coöperation			
1. Have visitors been assisted by making them feel they are guests?........			
2. Have visitors been assisted by answering questions?........			
3. Have visitors been assisted in finding a doctor?.			
C. Tact			
1. Has tact been shown in treatment of visitors?.			
D. Humor			
1. Has the humor of otherwise annoying situations been noted?........			
III. *Interest in Learning and in Using Knowledge Gained*			
A. Have comparisons been made between normal children and patients cared for?........			
(a) As to physical condition?........			
(b) As to mental attitude?........			
(c) As to social adaptability?........			
B. Has more interest been shown in caring for the child?........			
C. Has there been improvement noted?........			
IV. *Remarks*			

(Date)................ (Signature)....................................

Supervisor.

To make the rating as objective as possible, each statement may be checked according to three degrees of fulfillment. The columns are designated (1) Noticeably or Several Times, (2) Once or Twice or to Some Degree, (3) Never. The questions to be answered have been worded so that the best answers do not fall consistently in the first column.

It was believed that wording the questions thus would call for more thoughtful reading of the questions as the ratings were being made. To score these measures, two points were given for the highest degree, one for the next highest and no point was given for the lowest degree of fulfillment. A total score of 122 is possible according to this plan.

The quality of nursing care given by thirty-six students was rated by this standard just before instruction in Preventive Pediatrics was to begin. Two ratings of each student were made, independently, by the supervisor and the assistant supervisor of the department in which the student was then receiving training. The scores of the students in this first rating ranged from 55 to 109. The students were divided into two groups of approximately equal ratings. One group studied "Preventive Pediatrics" and the other group was observed as a control.

Content of the Course, "Preventive Pediatrics"

WITH these preliminary preparations completed, the course in "Preventive Pediatrics" was begun on February 13. One lecture and one class conference were held each week for nine weeks. The writer conducted these classes. At the regular class period the following topics were discussed:

1. The normal child.
2. The influence of heredity upon the development of the child.
3. Environmental influences.
4. The physical growth and development of the child.
5. The growth and development of language and gesture.
6. The mental and social development of the child.
7. Health factors that influence the growth and development of the normal child.
8. Constructive play.

In addition to these discussions, the members of the class gave special reports on the material in the Children's Bureau pamphlets.

The conference periods were used for discussion of the visits of observation. At this time comparisons and contrasts of the child studied with the normal physical, mental, and social characteristics of the age level were made. The discussions aimed to evolve ways of improving the present education of the child and plans were made for the form in which final reports should be written.

Five observations were made by each student. To give some basis for our class discussion of the effect of environment upon the growth and development of the child, the first observation was made in the home. Two students, after receiving preliminary data from the Director of the Social Service Department, visited a home together. The nature of this visit was that of a friendly call. The following outline for this observation was not taken on the visit but was carefully studied before going, so that the student might focus her attention upon the important factors of the home environment.

OUTLINE FOR OBSERVATION OF HOME

I. Residence:
- Type—House
  - Apartment—floor
  - Hotel
- Location
- Neighborhood
- Yard space
- Rooms:
  - Number
  - Light
  - Sunshine
  - Air space
  - Ventilation
  - Heating
  - Cleanliness
  - Furnishings
- Noise

II. Parents:
- Appearance
- Health
- Expression:
  - Happy
  - Sad
  - Worried
  - Tired
- Attitude toward children
- Evidences of extravagance
- Evidences of wisdom in expenditures
- Do both parents work?

III. Children:
- Number
- Age
- Appearance
  - Well nourished
  - Clean
  - Clothing
- Response
  - To visitors
  - To parents
  - To other children
- Care of property

IV. Play
- Space
- Playthings

The written reports, as suggested by the students, were to contain the

following points: (1) a description of the home, the parents and the children; (2) the advantages and disadvantages of the environment for the development of the child; (3) recommendations for changes which might better develop the child.

At the beginning, the students were reluctant to make these visits, but this reluctance disappeared when the first two reported at conference the appreciation and joy which the parents showed because the nurse who cared for their child called upon them.

Other observations were made at the nursery school, at the kindergarten, and at the elementary school; and, for the purposes of comparison and contrast, one observation was made of a child who was then a patient in the hospital. For these observations the students followed the "Outline of Observation of Children" used at the University of California.

Outline of Observation of Children

Observer .... Date................. Hour......... to......
Code name of child observed .... Places ....

I. Make diagram of each situation in which child is observed. (Use mimeographed sheets when these are available.) Indicate in diagram, size, placement of equipment, of director and assistants, of children; record light and shade on sunny days.

II. Environment
  A. Air: Thermometer reading, ...; air currents noticeable, ...; drafts, ...; air quiet, ...; odor noticeable, ...; not noticeable, ...; unpleasant, ...;
  B. Light: sufficient, ...; insufficient, ...; glare,.......
  C. Equipment: For work (list items)
     For play (list items)
     1. What may this equipment be expected to contribute to the development of the pupils?
     2. What use is made of this equipment by the pupils?
     3. List equipment which appears to serve as stimulus to useless or detrimental activities.
     4. Summary: Strong and weak points in this environment.
        Observed effects on children.

III. Characteristics of group
  A. The Children: boys, ...; girls, ...; oldest, ...; youngest, ...; median age, ...; height of tallest pupil, ...; shortest, ...; median height, ...; weight of heaviest pupil, ...; lightest, ...; median weight, ...; number of pupils showing vision difficulties, ...; hearing difficulties, ...; defective nutrition, ...; other physical handicaps observed,...
     Number showing all signs of health as given by Chaplin......................................
  B. Group Activity: Time .... to ....
     Number of children taking part, ...; not taking part, ...; showing embarrassment, ...; puzzled, ...; idle, ...; in mischief, ...; wanting to "run things," ......; to help their mates, ...; to help adults, ...; to get help from mates, ...; from adults, ...; not interested in mates, ...
     Children showing special abilities
     Any evidence of speech pressure
     Of speech defects
  C. Relation of children and directors to conduct of group activity
     Commands by adults during observation
     Suggestions by adults during observation
     Commands by children
     Suggestions by children
     Conflicts among children
     How settled?
     Conflicts between children and adults
     How settled?
Remarks:

IV. **Record of Group Activities**

Describe activity of group over a period of at least twenty minutes. Record on a separate sheet of paper, headed thus:

Group Place Date

Time .... to .... Observer

Begin at......

2nd
5 minutes......

3rd
5 minutes......

4th
5 minutes......

V. **Summarize this group acitivity as to its effects (observable) on the children and the adults taking part in it:**

Desirable......

Undesirable......

Bodily Equipment—Signs of Health

A. Outward Manifestations of a Well Built Body

Hair: Plentiful, with a lustre due to sufficient natural oil.

Eyes: Bright and clear, moving normally, no squinting nor dark fatigue rings under eyes; mucous membranes pink, not inflamed.

Unobstructed Nasal Breathing: Ability to breathe easily through nose. Mouth closed, especially when exercising and sleeping.

Teeth: Clean and free from cavities. Well formed; well enameled; even. Grinding surfaces of molars meet. Upper jaw slightly overlaps lower in front.

Color of Skin and Mucous Membrane: Color of skin ruddy pink. Color of the mucous membranes of lips and eyes, and of the finger nails is definitely pink.

Quality of Skin: Slightly moist, clear, soft and smooth.

Subcutaneous Tissue: Fat beneath skin plentiful, and so firm that skin cannot be raised in deep, thin folds between fingers.

Muscles: Firm and strong. General muscular development rather than over-development of certain muscle groups.

Shoulders: May be sloping or squarely built but should not be rounded forward.

Chest: Broad and deep, with good expansion. From two to three inches is normal expansion, depending upon the age of the child.

Arms and Legs: Long bones are straight. Legs neither bowed outward nor inclined inward. Joints not enlarged out of proportion with the rest of limbs; strong, indicating well developed ligaments and overlying muscles.

Ankles: Inner and outer sides equally prominent; inner not projecting abnormally as when arches of the feet are weak.

Feet: Arches strong and limber. Some are normally higher than others. Inner borders straight from heel to top of great toe.

Weight: Suitable to height and age.

B. Outward Manifestations of a Well Functioning Body

Alert, happy expression: The close relationship between bodily and mental health cannot be to strongly emphasized.

Tongue: Moist, red, and clean.

Breath: Sweet.

Good posture: Ear, shoulder, hip, knee, ankle, in line.

Prompt, efficient muscular coördination.

Bodily repose: Freedom from constant, unnecessary activity.

Endurance: Ability to indulge in all ordinary exercise without undue fatigue.

C. Traits of Child

1. Use of Hands
    - Right—left
        - In eating
        - In washing hands
        - In writing
        - Other activities

2. Speech and Gesture
   Record conversation during observation
   Enunciation
   Voice
   Record gestures
3. Emotional Reponses
   Simple:
      Fear—turning away from
      Love—seeking
      Anger—violent resistance; tantrum
   Complex:
      Sympathy
      Homesickness
      Satisfactions: pleasures in food, in playthings, in companions
      Antipathy—to food, companions, occupations
4. Property:
   Interest in acquisition
   Care of own property
   Attitude toward property of others
   Care of property of others
   Care of common property
5. Response to other persons
   To adults:
      Docile
      Negative
      Suggestible
      To mates, own sex
      To mates, opposite sex

The written reports included (1) the general characteristics of the age level; (2) the traits of the child studied; (3) a twenty-minute diary record of the activities of the child observed; (4) comparisons and contrasts with the normal child of that age; (5) recommendations to further the child's development: (An example of a written report on a home visit, of an observation of a normal child, and of an observation of a sick child, will be found at the conclusion of this paper.)

Comments made by the students who were enrolled in this course may serve to indicate their opinion of the worth of such a course:

1. Pediatrics is doubly interesting since I have learned how to observe children and make comparisons.
2. Preventive Pediatrics has made me realise a child needs understanding and that in caring for a sick child we should appreciate the personality of that child and note the deviations from the normal.
3. This course has helped me to have a better understanding and appreciation of the reactions of sick children.
4. It has made me more thoughtful of the children.
5. Preventive Pediatrics makes me realise the importance of a healthy mind and body. It gives a more adequate appreciation of the reactions of the sick child.
6. Observing normal children emphasises slight deviations from the normal and, therefore, stresses prevention.

(To be concluded in the April Journal)

The Adelaide Nutting Historical Nursing Collection

STUDENT members of the History of Nursing Society of Teachers College are endeavoring to obtain for the Adelaide Nutting Historical Nursing Collection early editions of representative nursing textbooks. This Collection, due to Miss Nutting's indefatigable efforts and interest, has become a most valuable historical library. The number of textbooks is, however, very small. Because of the medium which these early textbooks offer for tracing the developments in nursing education, it is hoped that additions may soon be made. Accordingly, five books have been chosen with which to make a beginning. These are:

Kimber and Gray: Anatomy and Physiology, 1st to 6th edition.
Weeks-Shaw: Textbook of Nursing.
Boland: Handbook of Invalid Cooking.
Dock and Quimby: Materia Medica.
Robb: Principles of Nursing.

If you have copies of any one of these which you would like to contribute to the collection, will you please notify Virginia Dunbar, 106 Morningside Drive, New York, giving the date on the title page and on the back of the title page, and the edition, if given.

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Questions

Will you kindly publish again information regarding wearing of Red Cross pin? Some nurses are of the impression that it should be worn only when assigned to Red Cross duty; others say it may be worn on the left side of collar.

Answer.—In May, 1927, Miss Noyes published information on the use of the Red Cross badge, in the Department of Red Cross Nursing of the *Journal*. At that time she quoted the following regulations:

"Each nurse receiving a badge should make every effort to protect it against misuse and loss. In order to do this we call your attention to the regulations governing its use as approved by the National Committee on Red Cross Nursing Service April 28, 1921.

"First: It may be worn by an enrolled Red Cross nurse, only then as a badge and not as a pin.

"Second: When in Red Cross uniform it may be worn:

(a) With the indoor uniform to fasten the collar in front.

(b) With the outdoor uniform it may also be used to fasten the collar of the waist.

(c) It may be worn two inches below and three inches to the left of the lower left-hand point of the collar.

"Third: It may be worn at a Red Cross function with civilian clothes or with evening dress. When worn in this way, it must not be used as a pin, but should be worn on the left of the waist, in relatively the same position as described in (c) above."

It is an accepted rule that a nurse shall not prescribe or administer any drug or medicine without an order. Does that apply to such remedies as aromatic ammonia for fainting, sodium bicarbonate for flatulence, hot drinks such as whiskey for chills, and the giving of chemical antidotes in case of acute poisoning, or of ipecac in croup? Doctors and nurses here differ on these questions.

Answer.—The American Red Cross, in the Home Hygiene and First Aid classes, teaches the students to give aromatic spirits of ammonia after a fainting spell, if the patient feels weak; sodium bicarbonate by mouth for the relief of flatulence; and hot weak tea or hot water for cramps.

The National Organization for Public Health Nursing, in its *Manual of Public Health Nursing*, published in 1927, gives on page 25 certain general standing orders: "Standing orders are those orders for treatment and medication, endorsed by the local medical society, which can be used until a physician can be secured or when orders have not been left by the attending physician." Under Emergencies and Accidents it says: "Send for physician. First aid treatment until he arrives. If unable to get physician, staff nurse should get in touch with headquarters for orders." First aid treatment is usually understood to include the proper antidotes for any known poison. Most doctors would prefer to have the patient's life saved by the administration of a stimulant while they are being summoned, than to have nothing done.

It is usually possible to confer with the physician or the local medical society and arrange standing orders which can be followed while the doctor is being sent for. A spirit of cooperation and regard for the welfare of the sick will lead to the establishment of certain principles in conformance with the Medical Practice Act of the state, which is fundamentally for the protection of the patient.

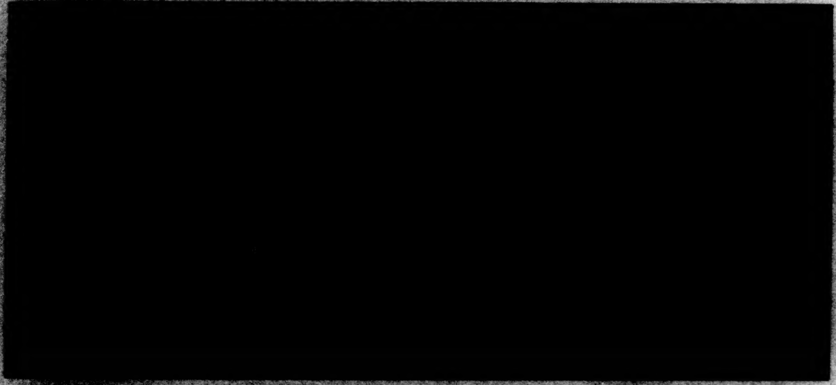
Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Jane A. Delano Week

THE week of March 12, the anniversary of the birth of Jane A. Delano, has been quite generally observed for several years as a suitable occasion upon which to arouse interest in the Red Cross Nursing Service.

The local committees on Red Cross Nursing Service are expected to take the initiative and, in coöperation with local nurse organizations, Red Cross chapters, and others, develop plans for recognizing this occasion. Nothing is more impressive than a large assembly of nurses, with graduates and students in their particular uniforms, in procession. With a good presiding officer, spirited music and an inspirational speaker, much interest and enthusiasm can be aroused. Interest in the Red Cross, and the importance of enrolling in its nursing service, as well as interest in nursing as a profession, its significance and importance to the life and general welfare of a given community, inevitably follow. In case it is not possible to arrange for a large assembly, many other methods, such as receptions, teas, pageants, tableaux, etc., have been successfully used for bringing enrollment to the attention of nurses.



IMPRESSIVE MARCH OF YOUNG NURSES AT JANE A. DELANO MEMORIAL SERVICE, AT WICHITA, KANSAS, MARCH, 1929.
(From the Red Cross Courier, Jan. 15, 1930)

With an enrollment of approximately 50,000 nurses, the average individual is justified in wondering why we need to increase the number. This enrollment is over twenty years old. Many of its members are now overage or physically disqualified, or through marriage have been transferred from the active to the inactive list. It has been estimated that less

than two-thirds of those enrolled would be available for service in case of some great national disaster. It therefore becomes of paramount importance that a steady stream of young graduates flow into the enrollment each year. To be specific, at least 200 new enrollments each month are required to keep the service at its maximum strength and usefulness. Let us all keep this occasion in mind, and by working together bring many young nurses into the Red Cross Nursing Service—a distinction which every nurse should covet and strive to attain.

The Approaching Red Cross Convention

MAY 5–8, inclusive, has been selected by the American Red Cross for its annual convention. To this hundreds of chapter delegates and members will come. All Red Cross nurses will be welcomed, particularly members of our local committees and chapter nurses.

It is this convention to which the state associations are privileged to send an official delegate. Formerly they came to the annual meeting. We hope these have already been selected by the boards of directors; we would, therefore, be very glad to have their names as early as possible. The program sounds interesting. Several social events are being planned for the entertainment of delegates and guests. In early May the Nation's capitol should be wearing its loveliest spring gown. Nurses who are planning a spring jaunt will find it well worth while if they include a visit to Washington during those early days of the month of May.

Our Mail Bag

FROM far and near come letters from Red Cross nurses. All are most welcome, but those from nurses in foreign countries are always of particular interest. We quote from a few of these for the benefit of those of our readers who are not so fortunate as this office. It happens that two of these come from nurses of the same surname as the National Director. For many years we rested under the impression, a mistaken one it seems, that we had the monopoly of the field in this particular connection.

From Mersifon, Turkey, Fanny G. Noyes sends her best wishes for a Happy New Year, returns her annual questionnaire (nurses closer at hand might profit by this example), and expresses regret that so far the hospital which they had hoped to have in operation is still unopened, partly because they have been unable to secure an American physician. She is also hoping to organize some classes in Home Hygiene and Care of the Sick for the students in the girl's school.

From Paris, France, the American University Women's Center, at 4 Rue de Chevreuse, we hear from Harriet Noyes, the nurse in charge of the clinic for American students and residents of the Latin Quarter, who writes:

> The Clinic is in charge of an all-American staff, and its services are free. Dr. A. Bruno of the American Hospital holds consulting hours here two days a week. The nurse in charge calls on students in their homes in the afternoons, or at any time when an emergency arises.
>
> This Clinic has been operating in the Latin Quarter for the past seven years and is in close contact with the American Hospital. It is under the auspices of the American University Women's Club, the American University Union, the Students' Atelier of the American Church, the Delaware University Group and the Smith College Junior group. It is intended to be of the utmost service in a medical or social way to the American residents of this district.
>
> It is a great asset to my appearance and

prestige to have been granted permission to wear the Red Cross cape and insignia.

4 Rue de Chevreuse is a name and place well known to hundreds of Red Cross nurses and other personnel, for it was the headquarters of the American Red Cross Commission to Europe for several years during and following the World War. Through the generosity of Mrs. Whitelaw Reid this interesting old place with its delightful grounds was made available to the organization.

Our next communication comes from India; Caroline E. Pope, who like all the others from whom we quote returned her annual questionnaire, writes:

I thank you for the Christmas message. Christmas season is always a strenuous one for us. As Hindus have many festivals throughout the year, so we make much of Christmas for our Christians, all mission schools give programs, there are dinners, and a community picnic, a watch night meeting, Sunday School program and church service. Another service is held on New Year's Day. We enjoy it all with our people, but we are glad when things get back to normal.

From Tilaunia, India, Agnes Dunn, who is connected with a Mission School, sends us a long letter full of Indian atmosphere, even to the inclusion of a story of the inevitable cobra and her final victory over this venomous serpent and its equally dangerous mate. Miss Dunn's description of the customs of the people of the country, their religious rites, etc., make most interesting reading. Following her cobra story, she writes:

The airplane story isn't so long, only this—that on October 20, one flew over Tilaunia. It was the first one I have seen in India, and the first to land in Ajmer.

The day I returned to Tilaunia the locusts were here. Now I know a bit about the plague of locusts in the Bible. Four times they came in dense clouds with a swirring of wings, settling so thick on trees that large limbs were broken off. They ate up a good deal but not as much here as in many other places. Indians roast and eat them. I ate several but couldn't see that there was much taste. . . .

These are busy days at our house. Helen Matthew sails for home on December 4, and Jean Bothwell arrives November 13 to take her place. Dr. Hoffman is also coming, but we are not sure yet what her appointment will be. Annual Conference begins in Lahor November 13. We are having our rooms color-washed and most of us are moving. This week Imogene Mitchell and her sister are arriving to visit me. I'm so thrilled over it. Imogene you know taught in a Mexican school and lived with me my last year in the U. S. A. She and her sister are touring the world.

A good many of our folks are having malaria and we are giving the preventive dose of quinine or cinchona. I take some myself.

When I came home September 24, there were so many patients that I thought we would have to buy more beds, but several have gone home and we are not so crowded. Six or eight were discharged as arrested cases.

The weather is pleasant, nights cool enough for two or three blankets, days sunny and warm. It rained more this year and our lake was full when I came home, it is nearly gone now and crops will be planted in its bed.

Enrollments Annulled

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Mabel C. Shotwell; Pearle Showalter; Rose Lillian Shumway; Mrs. J. T. Simmons, *née* Annie May Goode; Mrs. Grace Simmons, *née* Chamberlain; Mrs. Emma Evalena Simons, *née* Juergens; Sister Mary Felicitas; Sister Mary Thaddeus; Mrs. Emma L. Skeen; Edith Mathilda Smith.

A CORRECTION—In the February issue of the *American Journal of Nursing*, the Department of Red Cross Nursing contained a résumé of the recommendations framed by the Advisory Committee of the League of Red Cross Societies.

Recommendation VII should read: "refers to the use by Red Cross Societies of the principles laid down by the Education Committee of the International Council of Nurses" instead of "by the Education Committee of the League of Red Cross Societies."

Student Nurses' Page

A Bacteriological Study of Clinical Thermometer Technic

RUTH ASHBURN

Washington University School of Nursing, St. Louis

A BACTERIOLOGICAL study of our clinical thermometer technic, using bichloride of mercury as a disinfectant, was undertaken by the writer as a part of advanced work in bacteriology. A systematic study was carried out, primarily as a demonstration for classes of younger students, but the results are thought to be of sufficient general interest to warrant this report. The work was done under the direction of Dr. Kenneth L. Burdon, of the Department of Bacteriology, Washington University School of Medicine, who is instructor of Bacteriology in the School of Nursing.

Reports of previous bacteriological studies on this subject are few.

Doctors Force and Kerr[1] of the University of California tested the germicidal effect of varying strengths of alcohol on clinical thermometers. They found that 50 per cent alcohol sterilized mouth thermometers in four minutes, providing the thermometer was first wiped off with a cotton sponge wet with water to free it of mucus before it was placed in the alcohol.

In a recent number of the *American Journal of Nursing*, A. Frances Fischer and Catherine Simonds[2] described a bacteriological study of their technic for mouth temperature-taking, using 1:60 solution of phenol as a disinfectant. They found that a thermometer, after it had been wiped with a cotton sponge wet with green soap solution, must remain in 1:60 phenol solution for ten minutes in order to be sterilized.

A few days before my study was completed an article entitled "Studies in Thermometer Technic," by Martha E. Erdman and Margaret Welch,[3] was published in which appears the first report on the efficiency of bichloride of mercury as a disinfectant for clinical thermometers. These authors immersed thermometers in cultures of B. coli in a specially prepared medium made from eggs, starch and milk. They then tested the efficiency of alcohol 70 per cent, phenol 5 per cent, and bichloride of mercury, as sterilizing agents for these artificially contaminated thermometers. The results showed that thermometers contaminated from B. coli cultures which

[1] John N. Force and William J. Kerr: "Efficient Disinfection of Hospital Clinical Thermometers," *Modern Hospital*, August, 1929, p. 156.

[2] A. Frances Fischer and Catherine Simonds: "A Modern Hospital Takes Its Temperature," *American Journal of Nursing*, January, 1930, p. 39.

[3] Martha E. Erdman and Margaret Welch: "Studies in Thermometer Technic," *The Nursing Education Bulletin*, Vol. II, No. 1, p. 3. Department of Nursing Education, Teachers College, Columbia University.

had been rinsed in 10 per cent green soap solution were sterilised by immersion in bichloride of mercury 1:1000 solution for one minute, while alcohol 70 per cent and phenol 5 per cent required *more time*. They recommend immersing thermometers in bichloride of mercury (1: 1000) for one minute as a routine procedure in temperature taking.

These studies of Misses Erdman and Welch clearly indicate that bichloride of mercury is a reliable disinfectant for a contaminated thermometer and more rapid in action than alcohol or phenol but, since these authors used artificially contaminated thermometers only, it is doubtful whether their results could safely be taken as a guide to the actual practice of thermometer disinfection. The effect of disinfectants upon thermometers contaminated from cultures is very likely to vary with the resistance of the particular strain of test organism used, the age of the culture, or the nature of the culture medium. The colon bacillus, which was used as a test organism, is not representative of types of bacteria present on mouth thermometers. Staphylococcus is a better representative and usually is more resistant.

The action of disinfectants on glass rods contaminated with B. coli or staphylococci was tested by the writer in the following experiments: A number of glass rods, of the same size as thermometers, were placed in twenty-four-hour growths of staphylococcus albus and B. coli in a milk medium for three to five minutes. When removed from the culture, the rods were handled as thermometers are cared for, in the routine thermometer technic described below. The presence of large numbers of the test organisms on the rods was controlled by microscopic examination and by inoculation into the identical broth medium used in the tests. Separate rods thus contaminated were immersed in bichloride of mercury 1:2000 for one-half, one, and two minutes, and in alcohol 50 per cent and phenol 5 per cent for one, one and a half, two, five and ten minutes. On removal from the disinfectant, the rods were tested for the presence of living organisms by inoculation of test tubes containing plain broth. The tubes were incubated at 37.5 degrees C. for forty-eight hours. Any growth in these tubes showed that the rod had not been sterilised.

The results were identical with both test organisms and may be tabulated as follows:

ACTION OF DISINFECTANTS ON GLASS RODS CONTAMINATED WITH BACILLUS COLI OR STAPHYLOCOCCUS ALBUS

Disinfectant	*Time in Disinfectant*	*Results*
Phenol, 5%	1, 1½, 2, 5, 10 minutes	Rod sterilised
Alcohol, 50%	1 minute	Rod not sterilised
Alcohol, 50%	1½, 2, 5, 10 minutes	Rod sterilised
$HgCl_2$ (1:2000)	½ minute	Rod not sterilised
$HgCl_2$ (1:2000)	1, 2 minutes	Rod sterilised

Control cultures of each organism (without disinfectant) gave abundant growth.

If taken at their face value, these results would indicate that phenol 5 per cent, or $HgCl_2$ (1:2000) will sterilise a thermometer contaminated with B. coli or S. albus within one minute, whereas alcohol (50 per cent) requires a minute and a half. But these conclusions do not agree entirely with those of the authors mentioned above, nor do they agree with my own results reported below when naturally

contaminated thermometers were used in the tests. I do not believe that tests on thermometers contaminated from laboratory cultures should be relied upon as an accurate guide to clinical thermometer disinfection.

All of the following studies were made upon thermometers contaminated *in actual use* after taking mouth or rectal temperatures.

Study of Mouth Thermometer Technic

1. *Types of Microörganisms on Mouth Thermometers.*

In order to determine the types of microörganisms on clinical thermometers after taking mouth temperatures, blood agar plates were inoculated by streaking the end of each thermometer over the surface of a plate, immediately after its removal from the patient's mouth. The medium used in this and later work was proteose peptone agar plus about 5 per cent fresh human blood. After incubation at 37.5 degrees C. for twenty-four hours all plates showed heavy growths of different types of colonies, many of which were surrounded by green zones or by clear zones of hemolysis.

Representative cultures of mouth thermometers from ten different patients were carefully studied. Smears were made from the colonies and stained by Gram method. Staphylococcus colonies were transplanted to plain agar for pigment. The bile solubility test was tried upon organisms from the very small green colonies in order to differentiate streptococci and pneumococci. All organisms tested were insoluble in bile and no pneumococcus colonies were identified.

The following types of microorganisms were found to predominate in all blood agar plates from mouth thermometers:

Staphylococcus albus and aureus (all plates)
Streptococcus viridans (9 out of 10 plates)
Streptococcus hemolyticus (6 out of 10 plates)
Gram positive diplococcus (unidentified) (7 out of 10 plates)

Other microörganisms found were a large unidentified Gram positive coccus and large Gram positive bacillus resembling a diphtheroid.

It is clear that mouth thermometers always bear numerous bacteria, including streptococci and other types which may be pathogenic.

2. *Disinfection of Mouth Thermometers.*

The clinical thermometer technic taught in the School of Nursing, Washington University, is as follows:

A white enamel tray, 8" x 5" x 2", containing a jar with $HgCl_2$ 1:2000 solution for mouth thermometers (one thermometer for every six patients), a jar with $HgCl_2$ 1:2000 solution for rectal thermometers, a jar of vaseline, a jar of clean cotton, a jar of 10 per cent green soap solution, a jar of clean tap water, and a jar for waste cotton, is furnished for each hospital ward.

Procedure for Taking Mouth Temperatures

1. Remove thermometer from $HgCl_2$ 1:2000 solution.
2. Wipe dry with small piece of cotton, wiping from tip of thermometer toward part held by fingers.
3. Shake down to below 36 degrees C.
4. Place well under tongue of patient.
5. Pass out other thermometers in same manner.
6. Go back to first patient, count pulse and respirations. Remove thermometer, read and record.
7. Cleanse the thermometer in following manner:
   (a) Dip small piece of cotton in green soap solution.
   (b) Wipe off thermometer with soapy cotton, wiping toward tip, holding the thermometer over jar for waste cotton. Discard cotton.
   (c) Dip another small piece of cotton in jar of clean tap water, rinse

thermometer with wet cotton. Discard cotton.

(d) Place thermometer in $HgCl_2$ 1:2000.

8. Handle all thermometers in same manner.
9. When finished taking temperatures, clean up tray and change solutions.

In testing the efficiency of this technic, glass rods of the size of mouth thermometers were used instead of thermometers, and usually several were placed in the mouth in order to permit comparative tests at one time on rods contaminated from the same source. Each step of technic described above was followed as in taking routine ward temperatures. Blood agar plates were inoculated with the rods after various steps of the procedure and after immersion in $HgCl_2$ (1:2000) for varying lengths of time.

In each test, one portion of the plate was inoculated with the glass rod directly as it was removed from the patient's mouth, another portion after the rod had been wiped with soapy cotton sponge, and another after it had been wiped with cotton wet with tap water. Growth always occurred in these cultures and was of the same character and nearly as abundant in cultures from rods which had been wiped as in those from the untouched rod, thus demonstrating that wiping with soapy cotton certainly does not sterilize, and the use of a disinfectant is necessary.

TABLE I—Series of Tests with Mouth Thermometers

Growth Before Cleansing		Growth After Cleansing	Number of Minutes in Disinfectant ($HgCl_2$ 1:2000)		Number of Thermometers Tested	No. Showing Growth after Removal from Disinfectant	Per Cent Sterilized
Yes	Cleansed with cotton wet with 10% green soap solution, then with tap water	Yes	8	Wiped lightly with dry cotton to remove excess disinfectant.	2	0	100
"		"	6		2	0	100
"		"	4		2	0	100
"		"	2		16	0	100
"		"	1½		10	0	100
"		"	1		8	4	50
"		"	½		10	10	0

Glass rods which had passed through all the steps of the routine technic were then placed in bichloride of mercury solution (1:2000) for intervals of one-half, one, one and one-half, two, four, six and eight minutes. Upon removal from the disinfectant the rod was wiped lightly with dry cotton and used to inoculate blood agar plates. The results (shown in Table I) may be summarised as

TABLE II—Series of Tests with Rectal Thermometers

Growth Before Cleansing		Growth After Cleansing	Number of Minutes in Disinfectant ($HgCl_2$ 1:2000)		Number of Thermometers Tested	No. Showing Growth after Removal from Disinfectant	Per Cent Sterilized
Yes	Cleansed with cotton wet with 10 per cent green soap solution, then with tap water	Yes	½	Wiped lightly with dry cotton to remove excess disinfectant	5	5	0
"		"	1		10	5	50
"		"	1½		10	2	80
"		"	2		10	0	100

follows: All plates inoculated with rods immersed in bichloride of mercury for one-half minute showed growth; four out of eight plates inoculated with rods after one minute in bichloride of mercury showed growth; all others were sterile.

The results indicate that bichloride of mercury 1:2000 solution is an efficient disinfectant for the clinical mouth thermometer, if it has been cleansed with soapy cotton according to technic before being placed in the disinfectant, and providing it remains in the solution for at least one and one-half minutes.

Study of Rectal Thermometer Technic

SINCE it is routine in our institution for temperatures of the medical patients to be taken per rectum, it was important to test the efficiency of the technic using rectal thermometers. Cultures were made from rectal thermometers in the wards directly after their use in routine temperature-taking. The same medium and method of inoculation was employed as in the tests with mouth thermometers.

1. *Types Microörganisms on Rectal Thermometers.*

There were heavy growths on all plates inoculated with thermometers directly after removal from the rectum. A study of ten representative cultures showed that the most prevalent type of colony was a gray moist one which contained Gram negative, non spore-bearing bacilli. This organism fermented dextrose, lactose, saccharose, and mannite with acid and gas and was identified as a member of the B. coli group. Other types found were large Gram positive cocci, staphylococci, a few streptococci, and long Gram positive bacilli. No spore-bearing bacteria were seen.

It is certain that rectal thermometers are always heavily contaminated, organisms of the B. coli group being most numerous.

2. *Disinfection of Rectal Thermometers.*

Test cultures were made using the same technic for handling the rectal thermometers and for inoculating the blood agar plates as was employed in the mouth thermometer tests. The results are summarized in Table II. All plates inoculated with rectal thermometers after immersion in bichloride of mercury for one-half minute showed growths. Five out of ten plates inoculated with thermometers after immersion in the disinfectant for one minute, and two out of ten plates inoculated after immersion of thermometer for one and one-half minute showed growth. All thermometers exposed to the disinfectant for two minutes proved to be sterile.

The results indicate that our technic for cleaning and sterilizing rectal thermometers is efficient, providing the thermometer remains in the bichloride of mercury 1:2000 solution for two minutes.

Necessity for all steps in the routine thermometer technic

ONE remaining question seemed worth investigating, namely, can any step in the routine be safely omitted? In order to test this, mouth and rectal thermometers were placed directly into bichloride of mercury solution without any previous cleaning, others were wiped with dry cotton only, and others with wet soapy cotton before placing them in the disinfectant. Cultures on blood agar plates were made as before. The results show (Table III) that the treatment of the thermometer before placing it in the disinfectant is an important factor in relation to the time needed for its sterilization. Thermometers not wiped, or wiped with dry cotton only, are not surely sterilized by bichloride of mercury 1:2000 within two minutes. Wiping the thermometer with a soapy cotton sponge, as called for by the routine technic, is apparently a necessary step

TABLE III—EFFECT OF CLEANSING THERMOMETER BEFORE DISINFECTION

	Growth Before Cleansing	Cleansing Agents	No. of Minutes in Disinfectant ($HgCl_2$ 1:2000)		No. of Thermometers Tested	No. Showing Growth after Removal from Disinfectant	Per Cent Sterilized
M. Therm.	Yes	None	1½	Wiped lightly with dry cotton to remove excess disinfectant.	2	2	0
" "	"	"	2		2	2	0
" "	"	Dry cotton	2		2	2	0
" "	"	Wet soapy cotton	2		2	0	100
R. Therm.	"	None	2		2	2	0
" "	"	Dry cotton	1½		1	1	0
" "	"	Dry cotton	2		2	1	50
" "	"	Wet, soapy cotton	2		2	0	100

in order to insure its sterilization within two minutes.

Summary and Conclusion

BLOOD agar cultures made from mouth and rectal thermometers directly after use showed that thermometers are always heavily contaminated. Mouth thermometers bear staphylococci and many streptococci and other potentially disease-producing organisms. Rectal thermometers are contaminated with several kinds of bacteria, bacilli of the colon group predominating.

Thermometers (or glass rods) naturally contaminated as used were carried through the routine technic for mouth and rectal temperatures as taught in the Washington University School of Nursing, and cultures were made after various steps in the procedure and after immersion of the thermometers in the disinfectant ($HgCl_2$ 1:2000) for varying lengths of time. The results showed that the routine is efficient for the disinfection of both mouth and rectal thermometers. It was found that $HgCl_2$ 1:2000 will sterilize mouth thermometers in one and one-half minutes, and rectal thermometers in two minutes, provided the thermometer is wiped with a soapy cotton sponge before placing it in the disinfectant. The thermometer will not be sterilized with certainty within two minutes if it is not wiped before disinfection, or if it is wiped with dry cotton only.

These findings clearly indicate that bichloride of mercury 1:2000 is an excellent disinfectant for clinical thermometers. It is economical in cost and rapid in action. On the basis of these results an immersion of the soap-cleaned thermometers for three minutes in a 1:2000 solution may be considered a safe interval under any circumstances and students might be taught this as the minimum time. This rapid action of bichloride of mercury is one of its greatest advantages, for time is an important factor in a hospital where only a limited number of thermometers are used for a ward of thirty or more patients.

Bandaging Contest

HAZEL SANDY

St. Elizabeth's Hospital, Richmond, Virginia

TWENTY-EIGHT student nurses competed in the annual bandaging contest. While contestants are essential to a contest, there are two other equally important requirements and they are: judges and prizes. We had every essential! There were five most worthy and honorable judges.

The room in which the contest took place was artistically decorated in blue and gold, the official colors of the school—all in all it was very picturesque! Last year's group argues that their contest was even more so because they used Boy Scouts as subjects, while we used our next-door neighbors.

The following bandages were applied and graded: (1) Spiral Reverse of the forearm; (2) Barton; (3) Recurrent of the head; (4) Velpeau. After much complicated calculating the judges announced: A tie between the two nurses wearing the numbers "25" and "27." As is the custom a fifth bandage, Gauntlet, was applied by the two making equal scores. Still the difference was not great enough to declare one victorious and identical prizes were awarded: two hypodermic syringes which thrilled the recipients greatly! As a result their desire to enter the nursing profession seemed to increase immediately.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

Canadians Unwelcome?

IT seems that the slumbering spirit of graduate nurses of this country is just beginning to bestir itself with regard to a very definite menace. I refer to the hordes of Canadian graduates who continue to pour down into our already overcrowded field. The situation here in New York looks almost hopeless—so much so that my suggestion is that we rope off New York for Canadian nurses only and retreat with honors before we are starved out.

You can see and I can see that it is not fair to ask the Canadians to stay at home where their services receive such poor pay. As for their hospitals, I cannot but admire these thrifty neighbors—"Why pay our graduates higher wages when the United States good-naturedly takes care of all the surplus we can turn out. 'Low wages and more student nurses,' our method."

Is this not neat and orderly management, and can you blame their nurses for little conceits, such as "But you know we make the better nurses!" One would expect them under the circumstances to become chesty and complacent about themselves.

I wonder how far we would get if the conditions were reversed and we were to emigrate to Canada? I think we would be taught a lesson which might cure us of our easy-going dispositions.

A PRIVATE DUTY NURSE.

New York.

[The resentment of private duty nurses, whose numbers greatly exceed the demand for private duty service, over an influx of nurses from other countries is easily understood. However, not all such nurses should come in for wholesale condemnation. Nurses who come from Canada, and other countries, who become citizens, and participate in the work of professional organizations and other activities tending toward the advancement of nursing, should not be condemned. To do so would be utterly un-American. On the other hand, we have nothing but condemnation for selfish folk, nurses or others, who come to our shores solely for what they can get from the country and from the profession, and who give no loyalty to country and profession in return.—EDITOR.]

From a Medical Board to a Board of Nurse Examiners

A NUMBER of complaints have been received by this Board of trained nurses having undertaken to give various kinds of treatments, accepting the patient direct. These treatments, at the present time, seem to be, particularly, colonic irrigations, but there is also a certain amount of physiotherapy being administered. As yet none of those against whom complaints have been made have been registered, although several have claimed to be graduate nurses. I know, however, personally, that several registered nurses are accepting people direct for colonic irrigations, and in doing so they are violating the medical practice act.

My purpose in writing to you is to call your attention to the fact that the New Jersey law defines one as practicing medicine who undertakes by any means or methods to diagnose, treat, operate or prescribe for any human ailment. Section nine of the act makes certain exceptions, and among these exceptions is the nurse, who is permitted to do certain things under the specific direction of a legally licensed physician. The performance of these same treatments, such as colonic irrigations, if not done under the specific direction of a licensed physician is illegal, and is the practice of medicine.

Inasmuch as there seems to be such a wave of enthusiasm for colonic irrigations, given without proper medical advice or supervision, I should appreciate it if you would call it to the attention of the proper authorities. The prosecution of these individuals is liable to follow if the law continues to be violated. In other words, if complaints are received it becomes my more or less unpleasant duty to proceed with the prosecution. In certain instances I should dislike to do this, but under the law it would be my duty. Personally, I should prefer very much the enlightenment of the nursing profession by your Board, and by the State Nurses' Associations.

CHARLES B. KELLEY, *Secretary.*

New Jersey.

Nursing Code of Arizona State Board of Nurse Examiners

AT the request of the Arizona State Board of Nurse Examiners, we publish the entire section of their Nursing Code which was referred to in the December *Journal*, page 1516.

SECTION 4. If the result of the examination of any applicant shall be satisfactory to a majority of the Board, the secretary shall, upon an order of the Board, issue to the applicant a certificate to that effect, whereupon the person named in the certificate shall be declared duly licensed to practice professional nursing in this state for the period of one year from the date of the recording of such certificate in the office of the Recorder of the County wherein said applicant resides; provided, that such certificate may be renewed annually thereafter without examination, or the performance of any duty other than the payment of an annual license fee of one dollar to the treasurer of the State Board of Nurse Examiners and the recording of such renewal certificate in the office of the Recorder as aforesaid; provided further, that the County Recorder shall record such certificates upon the payment of a fee of one dollar and shall record such renewal certificates without charge.

Effective July 21, 1927.

X-Ray Films and Fire Hazards

IN the article, "An Experiment in Segregating Nursing Orders," in the January number of the *Journal*, appears the following paragraph: "Pockets were formed of washed x-ray films, and stitched to the scrap book by machine."

I am calling your attention to the fire hazard connected with the use of even such small portions of x-ray films, and would suggest that you call attention to the danger, and perhaps some other material, equally suitable for the pockets, can be substituted.

G. O'H., M.D.

New Jersey.

[I thought some one would bring up an objection to using x-ray films for pockets in the notebook used for segregating nursing orders. I had also asked about it before using it. Besides, I tried a match to a film with some trepidation on account of the alarming occurrence of last year. However, it burned no more quickly than thick paper, and a lighted match laid on top of it went out without igniting it. The reason for using it was that of economy in something experimental. Search for more suitable material has been instituted.

ELIZABETH M. JAMISON, R.N.]

Fabiola Hospital Association,
Oakland, Calif.

Too Many Nurses in These Localities

I

TO nurses contemplating coming to Miami we wish to present the following facts: There are several hundred nurses out of employment in Miami at the present time. There is less work here now than there has been at any time during the past eleven years. Florida has passed a state law that all nurses practicing their profession in this state pay a tax of $15, this being county and state tax. This, added to the state registration fee, makes a total of $25 that has to be put out in order to nurse in the State of Florida.

ANNIE ALLEN LAMBERT,
Registrar.

Florida.

II

NURSES are advised not to come to Oklahoma for work, as the private duty field is more than full. It may seem a little inhospitable, but it is not intended to be that way. We feel that it will save both time and money to know the situation before coming.

MARJORIE W. MORRISON,
Secretary, State Nurses' Association.

Oklahoma.

Anonymous Writers

"E. R. E." and other writers of unsigned letters are reminded that the *Journal* does not publish answers to such communications. Many of them would receive a careful analysis of their problems and, when possible, suggested solutions if it were possible to send a personal reply. This, of course, is not possible when signatures and addresses are not appended. The editors endeavor to handle personal problems with the same care they would wish to have given their own, were the situations reversed.

Journals Wanted and on Hand

ANNA NEWLIN, Indiana University Hospitals, Indianapolis, Ind., wishes to secure copies of the *Journal* for October, 1926, and June, 1929. She will give away for the postage: 1927, November and December; 1928, August through November.

Abstracts

Frank E. Chapman, M.D.: The Care of the Patient of Moderate Means. (*Hospital Social Service*, New York, November, 1929.)

Hospitals are subject to the same economic laws as other activities. A successful operating procedure presupposes the establishment of a balanced budget of income and expense. The correctness of a policy that contemplates one class of patients paying, in a large measure, for other groups is controversial. For the purposes of discussion in this article, attention is called to a long established principle that the surplus accruing from the charges to certain groups of patients shall redound to the benefit of the under-privileged group.

It is believed, however, correct to submit that a patient insisting upon and receiving the luxury of a private room should be assessed cost of care plus a reasonable surplus. There is nothing, or there should be nothing, typical alone to private room service that renders a higher type of essential hospital service than is rendered in the semi-private or ward accommodations of the institution.

To summarize the facilities of the hospital, there are: the private room, the charge for which is predicated upon cost per patient per day, plus; the semi-private room, the charge for which is predicated upon cost (or less than cost) without profit; the semi-private ward upon which charge is predicated upon the patient's ability to pay; and facilities without charge for patients unable to pay.

It is believed that, in a very large measure, this general policy is followed by hospitals from which the community should expect community service.

If the policy outlined above is followed, then to successfully prove that the hospital is exploiting its patients, compels a proof of inefficiency of operation, resulting in a cost of operation that is unnecessarily high. In 1927, a detailed study was made of the unit costs of operating one-half dozen hospitals in a large city comparing them with hotels and restaurants in the housekeeping, dietary and heat, light and power costs. An analysis of statistics is not always sound; but it is reasonable to assume that the figures derived from such analysis is an indication of the general efficiency or inefficiency of an institution. In the housekeeping department it was found that the cost per hundred feet for cleaning a hospital was approximately 30 per cent of the cost in hotels. In the heat, light and power department, the hospital showed approximately 70 per cent of the cost per cubic foot, as compared with the hotel. In the dietary department, an average of hospital costs showed a labor cost per meal for the hospital of approximately 40 per cent less and that the labor cost, plus raw food cost, was approximately 60 per cent of the cost for the hotels.

How many industrial plants in the country administer their activities at as low a cost in proportion to the total budget as the administrative cost of an institution? How many industrial laundries can show a production cost of less than one cent per piece handled? Any hospital laundry that shows a cost of one cent needs analysis.

Any hospital properly organized must be maintained at all times to be capable of meeting an emergency, rather than equipped to render only ordinary service. The hospital that follows a policy of holding its professional personnel down to a bare operating minimum is bound to get into difficulties. What may be a surplus of nurses on a given ward today is a shortage tomorrow, due to a larger ratio of acutely ill patients. Therefore, it is rather difficult to apply an economic measuring stick in the nursing problems with a degree of exactness that may be applied to some activities.

The cost per patient per day in American hospitals in 1928 ranges from $5 to $7.50, with a few rising above the larger figure and a few below the lower per capita cost. How many American plan hotels are there in the country in which complete maintenance can be obtained for an average of this per capita cost?

It is desired to reiterate that no one can successfully demonstrate that hospitals as a whole are inefficient. Taking it all in all, taking the hospital field as a whole, the American public is getting exceedingly fair return for the cost of its hospitals.

It is granted there is a universal opinion that hospital charges are too high.

What are we going to do for the patient of moderate means?

First, we must accept as our obligation the furnishing of every known means for the scientific diagnosis and treatment of disease, to every class of patient, irrespective of financial status.

Second, we must plan our physical plants, with a proper ratio of private, semi-private, and free beds, to the end that there will be physical facilities available for every group of patients.

Third, we must place in our admitting rooms socially-minded individuals, with instructions that the need of the patient must take precedence over the need of the institution.

In order to meet this added financial problem, our boards of trustees and administrative officers must accept the increasingly larger responsibility of providing ways and means for the subsidization of the part-pay patient, to the end that our hospitals may render a completer service and still operate soundly.

Malpractice: Abscess Following Hypodermic Injection by Nurse. *Journal of the American Medical Association*, December 21, 1929.

After an injection of ergot by a hospital nurse at the direction of the attending physician, an abscess developed. In a suit for malpractice the patient and her husband charged that the physician was negligent in that he made no inspection of the hypodermic needle prior to its use, gave no directions as to the place where the injection should be made and as to the manner and method of injecting, and permitted the injection to be made by a nurse. Admitting all this, the court concluded, it does not necessarily follow that the physician was culpably negligent; his culpability depends on the conditions and circumstances under which the injection was given. Had the patient been delivered in a private home where no antecedent preparation had been made, then unquestionably a physician would be negligent in allowing a hypodermic injection to be given without proper precautions, taken either at the time or at some prior time in anticipation of the necessity of its administration. But the delivery here took place in a well-appointed and well-equipped hospital, where emergencies were anticipated and prepared for in advance, where instruments were sterilized and kept for emergency uses, and where the physician was surrounded by trained assistants. The physician in the present instance knew of these conditions, and it would be too much to say that he was negligent in relying on them. The fact that he permitted the injection to be given by a nurse would not of itself give rise to an inference of negligence. Possibly, if it had been left to the nurse to determine whether or not the drug should be administered, it could be urged with some reason that the physician was negligent; but the act of administering the drug was mechanical, a part of the routine work of the nurse, and it was shown that the nurses in the hospital had been carefully and fully instructed in the mechanics of the art. The verdict directed by the trial court in favor of the defendants was affirmed.

"Malpractice," as Applied to Nurses. *Journal of the American Medical Association*, December 21, 1929.

The expression "malpractice" as used by the legislature of the state of New York in subdivision 1 of section 50 of the Civil Practice Act, defining the limitations of civil actions, was intended to apply and does apply to improper treatment of disease or injury by a nurse, through ignorance, carelessness or criminal intent. A nurse is entitled to take advantage of the two-year limitation fixed by the statute cited, in actions for malpractice, and is not relegated to the three-year period fixed for actions to recover damages for personal injuries resulting from negligence in general.

Psittacosis. Current Comment. *Journal of the American Medical Association*, January 18, 1930.

Surgeon General Cumming has detailed Dr. Charles Armstrong, an epidemiologist of wide experience, to conduct a field investigation of the individual cases of Psittacosis reported and to trace the source of the infection, which has been ascribed in practically every case to association with recently imported parrots. In the epidemic of psittacosis in Paris in 1892, which caused forty-nine cases and sixteen deaths, the parrots that carried the infection had been imported from South America. The disease is attributed to an organism called *Bacillus psittacosis* or *Bacillus aertrycke*, but there is doubt whether this organism is the real cause of the pneumonia transmitted to many by parrots. Some investigators, Jordan says, attribute it to a special variety of streptococcus. *Bacillus psittacosis* closely resembles *Bacillus paratyphosus*, *Bacillus suipestifer* and the bacillus of mouse typhoid (*B. typhi-murium*). The disease is essentially a medical curiosity and need occasion little alarm among the people of the United States.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

Digest of Minutes of the Directors' January Meetings

Consistent progress in the various projects and varied interests of the A. N. A. were reported to the Board of Directors at its January meetings in New York City.

Registries.—As a result of the Study of Official Registries being made at Headquarters a purely tentative "Minimum Standard for Official Registries" was submitted to the Board. It was voted by that body that the Standard be referred to the Registry Committee for its approval. When this has been received, the Minimum Standard will be sent out to the states with the statement that it is "recommended by the Registry Committee," with a request for suggestions for changes. It will then, with suggested changes, be submitted to the Board for final approval at the June meetings.

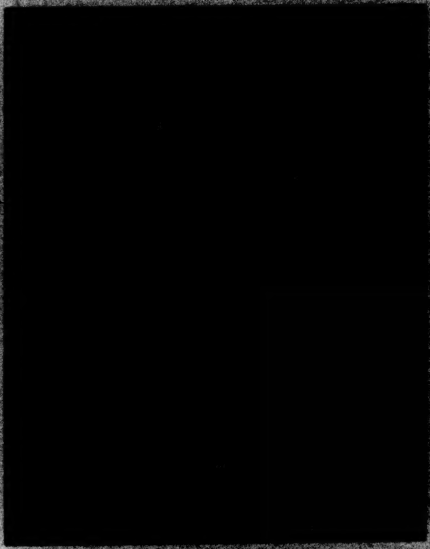
Relief Fund.—The Board of Directors went on record as believing in the need for discontinuing relief given on a national basis through the Relief Fund. The question of whether this fund could be diverted to the states so that the nurses dependent upon it for aid might be best protected; and if so, how best this could be done, the problem of the future use of the Relief Fund principal, were this fund to be discontinued; and the entire subject of relief giving, the Board voted, will be brought before the House of Delegates in Milwaukee.

Harmon Plan.—Closely knit with the problem of relief is the problem of insurance. The Board took action on this subject also by voting that "The Harmon Association be requested to employ some person, preferably a nurse well qualified to conduct an educational campaign on insurance and investment, and to urge membership in the Harmon Association."

Assistant Director.—A. N. A. Headquarters now has an Assistant Director at Headquarters, Mrs. Alma H. Scott, having been appointed to that position. Mrs. Scott has been a member of the Headquarters' Staff since July, 1929, having served as one of the field secretaries.

Bordeaux School.—The nurses of the country have given $32,152.39 to build the right wing of the Florence Nightingale School of Nursing at Bordeaux, France, thus completing the building erected in memory of the 296 American nurses who gave their lives in the World War. So announced the Chairman of the Advisory Committee, American Nurses' Memorial, Clara D. Noyes, telling the Board also of how Dr. Anna Hamilton, Superintendent, had been cabled to place bids for the wing, based on the original estimate of $25,000. The Government of France has made a gift to the School of 900,000 francs in recognition of Dr. Hamilton's contribution to nursing in France.

The Board made three important motions with regard to the "Florence Nightingale School," the first being that the money be sent to the trustees of the school in small amounts, as needed, and that checks be countersigned by Dr. Hamilton or her representative. An Alumnae Association for the Bordeaux School was urged, the Board voting that Dr. Hamilton be asked to take steps toward its formation, and that she name a small committee of from three to five graduates, none of whom is connected with the School, to act in this capacity. In order "to assist Dr. Hamilton and to protect the future of the School," the Board voted that a Training School Committee be formed, to consist, if possible, of the following members: The Chief Executive of the School; the Chief Executive of the Hospital; representatives of the Board of Trustees; members of the Alumnae



Anna Rich, R.N.
Chairman, Milwaukee Arrangements Committee

Association; lay persons, who have shown an intelligent interest in the School, to be designated by Dr. Hamilton.

Saunders' Medal.—A nursing medal, to be known as the Saunders' Medal, has been offered the nurses of the country by W. B. Saunders of Philadelphia. The recipient of the award, according to the wishes expressed by Mr. Saunders, is to be a nurse who has made to the profession or to the public some outstanding contribution, either in personal service, or in the discovery of some nursing technic that may be of advantage to the patient and to the profession. The only kind of service excluded is that of writing. It is the opinion of Mr. Saunders that the award should not be made to anyone because of the writing of books or articles. The A. N. A. Board ratified the recommendations of the three presidents that the personnel of the Committee chosen to make the award consist of two representatives from each of the three National Nursing Organizations, Mr. Saunders, and three persons who are not nurses to be appointed by the Joint Board of Directors. Names of nurses recommended to receive the award may be submitted to this Committee when it is established, by any state nurses' association or by anyone wishing to make such recommendation, the award to be made at any biennial meeting of the A. N. A.

White House Conference.—Emilie Sargent of Detroit, was appointed by the Board to represent the American Nurses' Association on the Sub-Committee on Interested Organizations of the White House Conference on Child Health and Protection.

Grading.—That most important subject, Grading, was discussed considerably by the Board. The services of the A. N. A. Publicity Secretary were placed at the disposal of the Grading Committee for such public information as might seem feasible and as would not interfere with her time in carrying out the A. N. A. publicity program. The appointment of Stella Goostray, as advisor to the Joint Nursing Committee on Educational Policies, was ratified by the A. N. A. Board. The time limit in the financing of Grading was placed in June, 1930, payable in pledges or cash. A motion carried "That the nursing profession assume the obligations, moral and financial, for assuring the continuation of the work of the "Grading Committee," and the principle was accepted in the recommendation whereby the nursing organizations carry on the work of the Grading Committee at the close of the five-year period set aside for its work.

Biennial Convention.—Several aspects of the Biennial Convention to be held in Milwaukee, June 9–14, were discussed by the Board. A motion carried that "a statement be prepared, outlining the principles that are involved in the selection of representatives to the Presidency and to the Board of Directors of the A. N. A."

A. N. A. delegates to Milwaukee, when they register, will receive "printed reports of those officers and committees which contain recommendations that require action." This excellent step was taken in order to expedite the opening business session of the A. N. A.

In order to clarify a situation which constantly causes confusion at biennial meetings, it was voted to send notices to the states reminding them that the voting body of the A. N. A. consists of accredited delegates, but that the privilege of the floor may be accorded to any member in good standing.

Government Nurses.—The Board took action, also, for that part of its constituency in the Government services. It endorsed the McSwain Bill which provides for the retirement of disabled nurses of the Army and Navy, this Bill having been introduced into the House of Representatives and referred to the Committee on Military Affairs. A motion carried that a letter be sent from the

A. N. A. Board of Directors, endorsing the principle of the measure which provides for the coördination of salaries of all the personnel in the Army, Navy, Public Health Service, Marine Corps, Coast Guard, and Coast and Geodetic Survey. The Board arranged, too, for the continuance of study of reclassification begun late in 1929.

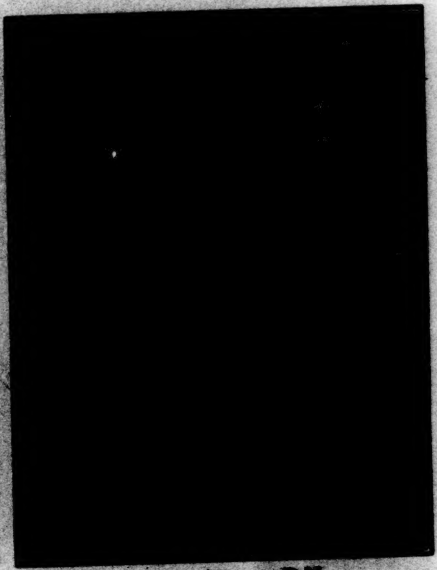
Committees.—It was voted that the following committees, formerly of a joint nature, become A. N. A. committees: International Relations, Ethics, American Nurses' Memorial, Harmon Association, Saunders' Medal, Delano Memorial.

The Ideal Magazine Committee, having recommended after a thorough study of the situation that both the *American Journal of Nursing* and the *Public Health Nurse* were needed publications and that there would be no advantage in combining the two, it was voted that it be discontinued. Other committees to be discontinued are the Triennial or Biennial Convention Committee and the Committee to Consider the Possible Association of Lay People with Nursing Organizations. It was voted, also, that since the Insurance Committee has, for the present, fulfilled its function by its work relating to the Harmon Association, that Committee be discontinued for the present. Because of the resignation of Mary C. Wheeler, Mary M. Roberts was appointed Chairman of the Committee on Ethics until the Biennial Convention.

Biennial Convention

Housing.—Make reservations early for the Biennial Convention in Milwaukee, June 9–14. There are a number of hotels in Milwaukee. Arrangements are being made so that every convention-comer will be accommodated. But if you want to be comfortably and conveniently placed according to your taste, make your reservations now. Stella Ackley, Milwaukee County Hospital, is Chairman of the Housing Committee, through which reservations can be made. This Committee includes as a member, also, a Roman Catholic Sister whose responsibility will be to secure the accommodations for those Sisters who do not wish to be housed in hotels. Many nurses, in fact, prefer to be as quiet as possible, and for them rooms are available in the residence districts of the city. The Committee is making arrangements, too, for dormitories for pupil nurses.

Dinners, Luncheons, etc.—Wednesday evening of convention week is designated as State Dinner evening. It is an excellent opportunity, a time of lull between activities and an



Stella Ackley, R.N.

Chairman, Housing Committee (President, Wisconsin League of Nursing Education)

evening when, instead of meetings, festivities fare forth. For Wednesday evening, from nine until twelve, the Wisconsin nurses will entertain. It would be a good idea, therefore, to plan dinners for Wednesday, going later in the evening to the major social event of Conventional Week. Delia Newton, Columbia Hospital, Milwaukee, is Chairman of the Dinner and Luncheon Committee, which is prepared to send by return mail detailed information as to menus, prices, and decorations.

Student Chorus.—A student chorus of 100 voices is being organized by the Local Arrangements Committee. Student nurses from various hospitals already have begun their work, the chorus being under the direction of the Marquette University School of Music.

Undergraduate Guests.—Undergraduate nurses are being urged especially by the Wisconsin leaders to attend the convention. "It is hoped," writes Anna Rice, Chairman of the Local Arrangements Committee, "many schools and alumnae associations will send pupil nurse delegates who can carry enthusiasm back to their schoolmates, and perhaps in this way" stimulate greater interest in organization work among the younger generation.

A committee has been appointed which is making special plans for the entertainment of undergraduate guests.

Transportation.—The *Identification Certificate Plan* has been selected whereby convention goers can travel at reduced rates. Reduced fares have been authorized over all roads, from all points throughout the country to Milwaukee. Under this arrangement those going to the convention will secure a *certificate* from (a) the Section Chairman of Transportation for the State; (b) or the Executive or Elected or General State Secretary; (c) or, if preferred, from F. M. Adams, Esq., City Passenger Agent, Baltimore & Ohio R. R., 122 East 42nd Street, New York City. This *certificate* entitles the nurse to purchase a ticket from her home station to Milwaukee at the reduced rate of a fare and one-half for the round trip. Tickets purchased under this plan will be valid for return passage up to and including June 20, 1930. And all that the nurse must do in Milwaukee is to have her return ticket stamped. Space has been set aside for this purpose in the Convention Auditorium in order to make this necessary stamping of return tickets as simple a matter as possible.

Routes.—Mountain States, of which the Transportation Section Chairman is Anna C. Jammé, 609 Sutter Street, San Francisco, California, will use the following roads in going to the convention: Southern Pacific, Union Pacific, Denver & Rio Grande, Rock Island, Chicago and Northwestern, and Chicago, Milwaukee & St. Paul. Cora E. Gillespie, 327 Cobb Building, Seattle, Washington, Chairman of the West Coast States, announces that the Great Northern R. R. will be the official route from those states. Emily J. Hicks, 370 Seventh Avenue, New York City, Chairman of the North Atlantic States, announces that travel from that section will be over the Baltimore & Ohio, New York Central, Pennsylvania, Chicago and Northwestern, and Chicago, Milwaukee & St. Paul.

The Canadian Nurses' Association invites Nurses to attend its convention to be held June 24–28 in Regina, Saskatchewan. If you are not familiar with the North, here is an excellent idea for a post-biennial trip. It is also an opportunity to become better acquainted with your nearest national nurse neighbors. Nurses in Canada and the United States always have been friendly, drawn close not only because they are neighbors but because their history has been interwoven. When organized nursing came into being in the United States, the Canadian nurses were participants and, as every nurse knows, what is now the American Nurses' Association was organized as the National Associated Alumnae of the United States and Canada. And although upon incorporation in 1901, the Canadian affiliation was discontinued because of the New York State Law prohibiting the admission into membership in an organization of citizens of another country, cordial relations always have existed between the nurse groups of Canada and the United States.

The American Nurses' Association already had sent an invitation to the Canadian nurses to attend the Milwaukee biennial when their invitation was received. So this summer's meetings should provide an excellent opportunity for furthering friendliness, an opportunity begun for many nurses last year when their Canadian sisters were hostesses to the International Council of Nurses.

Nurses' Relief Fund

Report for Month Ending January 31, 1930

Receipts

Interest received on investments..........	$992.92
Interest received on bank balances........	8.04

Contributions

Alabama: District 1, 212 members, $21.20; Hillman Hospital Alumnae Assn., $12...	33.20
Arizona: District 1..........................	138.00
California: State Nurses' Assn..............	174.00
Colorado: Alumnae associations—Glockner, $11; Bethel, $12; University, Denver, $10; St. Luke's, $10; Minnequa, $12; C. C. Nurses' Club, $6; individuals, $27.......	88.00
District of Columbia: Alumnae associations, Garfield, $28; Columbia and Children's, $30..........................	58.00
Florida: District 4..........................	3.00
Georgia: State Nurses' Assn., $50; Georgia Baptist Alumnae Assn., $35..............	85.00
Indiana: State Nurses' Assn..............	1,000.00
Iowa: District 7, Iowa Methodist Hospital Alumnae Assn., $12.50; District 9, Greater Comm. Hospital Alumnae Assn., $13..........................	25.50
Kansas: District 2, $14; District 7, $36....	50.00
Maryland: Individual..........................	1.00
Massachusetts: Alumnae associations—Boston City Hospital, $25; Emerson Hospital, $10; Bristol County Branch, $11.18; individuals, $2..............	48.18
Minnesota: Alumnae associations—St. Mary's, Duluth, $3; St. Mary's, Minneapolis, $22; Ancker Hospital, St. Paul, $2; individuals, $27..................	54.00
Missouri: Alumnae associations—Missouri Methodist, $14; Trinity Lutheran, $37; Grace Hospital, $16; Missouri Baptist, $122; Lutheran, $116.25; General, $156; Independence San., $1; individuals, $2; District 6, $12.25..................	476.50
Montana: District 2..........................	108.00
Nebraska: Immanuel Alumnae Assn.......	13.00

New Jersey: Alumnae associations—Muhlenberg, $125; Essex County Homeopathic Hospital, $35; St. Mary's, $30; St. James, $35; Presbyterian, $25; Elizabeth General, $15; Women's and Children's, $10.50; Orange, $2; Bridgeton, $15; individuals, $24.50	$317.00
New York: Alumnae associations—Jamaica, $20; Jewish, $25; Roosevelt, $50; Post-Graduate, $150	245.00
North Carolina: State Nurses' Assn.	254.00
Ohio: St. John's Hospital Alumnae Assn. (Cleveland)	50.00
Oklahoma: District 2	63.00
Pennsylvania: Graduate Nurses' Assn. of Pennsylvania	6,500.00
Tennessee: Alumnae associations—Knoxville, $35; Riverside-Fort Sanders, $68; individuals, $25	128.00
Texas: District 7, $54; District 13, $15; District 14, $16; District 16, $2	87.00
Total receipts	$10,999.34

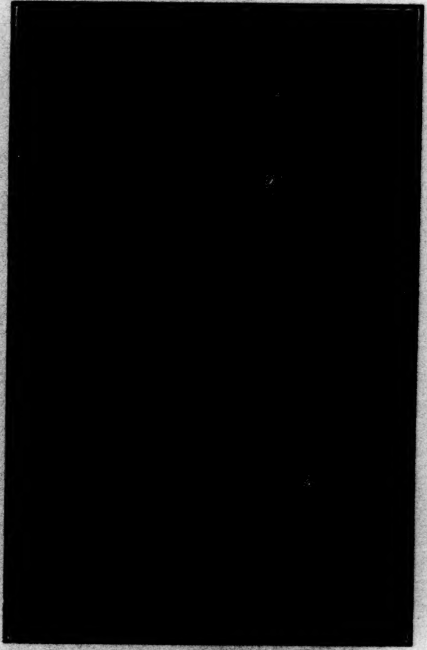
Disbursements

Paid to 192 applicants	$2,722.00
Salaries	270.55
Traveling expenses of committee	472.18
Miscellaneous expense	3.08
Total	$3,467.81
Excess of income over expenditures for month ending January 31, 1930	$7,531.53

All contributions to the Nurses' Relief Fund should be made payable to the *Nurses' Relief Fund* and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in each state. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman, or the Director of the American Nurses' Association, Headquarters, 370 Seventh Avenue, New York, N. Y.

The Isabel Hampton Robb Memorial Fund Committee

The annual meeting of the Isabel Hampton Robb Memorial Fund Committee was held at the Hotel Pennsylvania, New York, January 15, 1930. Reports of the officers for the year 1929 showed an increasing number of requests for scholarships and loans more than can be granted from the funds on hand. Seven scholarships of $300 each, and fifteen loans were given during the year. Four resignations from the Committee were accepted with regret: M. Adelaide Nutting, Lavinia L. Dock, Cecilia Evans, Abbie



CORNELIA VAN KOOY, R.N.
President, Wisconsin State Nurses' Association

Roberts Weaver. It was decided to give six scholarships of $300 each during 1930, unless an increase of funds should justify increasing the number. The members of the Executive Committee and the officers were reëlected: Chairman, Elsie M. Lawler; secretary, Katharine DeWitt; treasurer, Mary M. Riddle.

THE ISABEL HAMPTON ROBB FUND

Report to February 11, 1930

Previously acknowledged	$34,706.62

Contributions

Indiana: First District, $10; Lutheran Alumnae, Fort Wayne, $5; University Alumnae, Indianapolis, $5	20.00
Kansas: State Association	25.00
Pennsylvania: Mid-Valley Alumnae, Peckville	10.00
Rhode Island: State Association	10.00
Wyoming: State Association	5.00
	$34,776.62

MARY M. RIDDLE, *Treasurer.*

The McIsaac Loan Fund

Report to February 11, 1930

January 9, 1930, Balance	$371.32
Contributions	
Indiana: District 1, $10; Lutheran Alumnae, Fort Wayne, $5; University Alumnae, Indianapolis, $5	20.00
Kansas: State Association	25.00
Pennsylvania: Mid-Valley Alumnae, Peckville	5.00
Rhode Island: State Association	10.00
Wyoming: State Association	5.00
Loans returned in full or in part	576.00
	$1,012.32
Disbursements	
Loan made	200.00
February 11, 1930, Balance	$812.32

MARY M. RIDDLE, *Treasurer*.

Requests for scholarships or loans should be sent to the Secretary, Katharine DeWitt, Room 1819, 370 Seventh Avenue, New York. Contributions should be sent to the Treasurer at the same address. Checks should be made separately for the two funds.

The Ideal Magazine Committee

A résumé of the report presented by the Chairman, Mrs. Anne L. Hansen, to the Joint Boards of Directors, January 15, 1930:

In 1926, this Committee was appointed by the Joint Boards of the three national nursing organizations to study the problem of the amalgamation of the two official magazines, the *American Journal of Nursing* and the *Public Health Nurse*. Meetings have been held annually and a sub-committee has made a study of the needs of the nursing profession in the magazine field. The statement of the sub-committee showed six major divisions in the material: Education, Administration, Service, Professional Nursing Organizations, Community Organization, Legislation.

The four plans presented as a possible means of combining the magazines have been outlined in a previous statement. (See the *American Journal of Nursing*, December, 1929, page 1530.) Plan I was considered in detail, and it was found from a rough estimate of the finances involved that the anticipated income might be $152,700, and the possible expense, $140,535, for a year. No plan was worked out as to management or as to staff set-up. It was felt that the liabilities of the *American Journal of Nursing* would be increased by such a combination.

In discussing the report, the following points were brought out by members of the Joint Boards:

1. That there would be little financial benefit to the nurse subscriber, as against the present joint subscription rate.

2. There would be no saving of reading material, due to the necessity of publishing an N. O. P. H. N. voice organ.

3. That there was at present a distinct differentiation in the material carried by the two journals—the *Journal* supplying the clinical, technical material of the profession for the individual nurse, the *Public Health Nurse* dealing with the community aspects of public health, public health nursing projects, and the standards, policies and technics of the public health nurse in the special capacity as an individual or as a group.

4. That the discussion of the functional relationship of the three national organizations was placing the function of the two magazines in a different light, and changing the feeling in regard to the desirability of amalgamation.

5. That inasmuch as the present informal joint editorial council at headquarters showed promise of directing the publication of material, avoiding duplication, and as much could be gained on both sides, if each journal gave publicity to and urged subscription to both magazines at the combination rate, it seemed wise to continue on the present basis.

The motion was unanimously carried that plans for amalgamation having been carefully studied from every angle, over a period of three years, the two journals be continued as separate publications as at present, with a joint editorial council at headquarters to consider the material to be published, differentiating it along the functional lines of the three national nursing organizations.

This recommendation of the Committee was acted upon by the Joint Boards, January 17, accepted, and the Ideal Magazine Committee dismissed. All those present felt there was great promise of better service to the nurse in the field in this new plan of joint consideration of professional reading matter, and the editors of both journals are rejoicing that this moot question has finally been settled.

National League of Nursing Education

TICKET OF NOMINATIONS FOR 1930

For President

Elizabeth C. Burgess, New York, New York

For First Vice President

E. M. Lawler, Baltimore, Maryland
Daisy Dean Urch, Oakland, California

For Second Vice President

Elizabeth Soule, Seattle, Washington
Anna D. Wolf, Chicago, Illinois

For Secretary

Stella Goostray, Boston, Massachusetts

For Treasurer

Marian Rottman, New York, New York

For Directors

(Four to be elected)

Mary M. Roberts, New York, New York
Nellie X. Hawkinson, Cleveland, Ohio
Carrie M. Hall, Boston, Massachusetts
Annie W. Goodrich, New Haven, Connecticut
Mary M. Pickering, Berkeley, California
Gladys Sellew, Chicago, Illinois
Claribel A. Wheeler, St. Louis, Missouri

Dora Saunby,
Elizabeth Soule,
Edith Brodie,
Claribel Wheeler,
Florence Ambler, *Chairman,*
Committee on Nominations.

Be sure to pay your dues, so that you can vote for some of these candidates. If you are a member in a state which has no State League, send $5. directly to Headquarters. If you are a member of a State League, send your dues to the State League treasurer.

Army Nurse Corps

During the month of January, 1930, orders were issued for the transfer of members of the Army Nurse Corps to the stations indicated: To Fort Banks, Mass.: 2nd Lieut. Mary S. Emery; to William Beaumont General Hospital, El Paso, Tex.: 2nd Lieut. Bertha Purcell; to Fort Benning, Ga.: 2nd Lieuts. Lila Olson, [illegible] Potts; to Fort Eustis, Va.: 2nd Lieuts. Mildred L. Johnson, Anna G. Slater, Martha F. Stewart; to Fitzsimons General Hospital, Denver, Colo.: 2nd Lieut. Anna C. Keller; to Fort Francis E. Warren, Wyo.: 1st Lieut. Mildred F. Carter; to Letterman General Hospital, San Francisco, Calif.: 1st Lieut. Anna E. Carlson, 2nd Lieuts. Eleanor Conway, Mary E. Robinson, Ida May Shlevin, Minnie O. Vila; to Fort Lewis, Wash.: 2nd Lieut. Sylvia M. Williams; to Fort Sam Houston, Tex.: Anna Louise Alexander, Mabel Berry, Lulu J. Newton; to Fort Sheridan, Ill.: 2nd Lieut. Catherine M. Gemeinhardt; to Fort Slocum, N. Y.: 2nd Lieut. Louise M. Anschicks; to Fort Totten, N. Y.: 1st Lieut. Rae D. Landy, 2nd Lieuts. Helen J. Jurash, Estella Whitehead; to Walter Reed General Hospital, Washington, D. C.: 1st Lieut. Elizabeth Valine Messner, 2nd Lieuts. Sara C. Brogan, Helen V. Johnson, Elizabeth M. Deveney, Alice M. Kendrick, Helen M. Kenner; to San Juan, Porto Rico: 1st Lieut. Victoria Anderson; to the Hawaiian Department: 1st Lieuts. Bessie S. Bell, Angeline L. Staples, 2nd Lieuts. Rose C. Kettman, Maud A. Quinn, Beatrice M. Van Vleet; to the Philippine Department: 2nd Lieuts. Mary E. Haynes, Cornelia W. Heiss, Mary E. K. Mellor, Minerva O'Neale, Marie E. Reiners, Sara E. Scattergood.

The following are under orders for separation from the Corps: Ruth J. Beckman, Angena Beukema, Wirtie M. Butler, Anne C. Edelman, Mary B. Eglin, Marie C. Feehan, Isabel J. Guyette, Bert C. Harder, Elisabeth B. Ray, Hetty Shepard, Dorothy M. Waldo, Ruth E. Severeen.

Julia C. Stimson,
Major, Army Nurse Corps,
Assistant

Navy Nurse Corps

During the month of January, nine nurses have been appointed and assigned to duty:

The following transfers were made: to Annapolis, Md., Daisy B. Clark, Ruth B. Dunbar; to Canacao, P. I., Alice B. Newcomb, Frances C. Bonner, Mabel T. Cooper; to Great Lakes, Ill., Margaret W. Barnes, Polly E. Frost; to League Island, Pa., Ada E. Griffiths, Mary J. Hickey, Manila D. Barber; to Mare Island, Calif., Susan J. English; to Newport, R. I., Muriel H. Neate, Barbara M. Lubus, Gertrude M. Weber; to New York, N. Y., Ruby M. Hill, Rosa L. Lane, Josephine M. Lane, Isabella Gilfillan, Jutta J. Anderson; to Pensacola, Fla., Stella A. Dolloff; to Puget Sound, Wash., Mary F. Tuohy, Lillian M. Ward; to Quantico, Va., Fern M. Andre; to San Diego, Calif., Frances S. Denk; to St. Thomas, V. I., Katherine M. Leary; to Washington, D. C., Mary J. Jones.

The following nurses have been separated from the Service: Esther Weiland, Mamie I. Johnson, Eleanor J. Vance, Teresa C. Holt, Lona Smith.

J. Beatrice Bowman, R.N.,
Supt., Navy Nurse Corps.

U. S. Public Health Nursing Service

The following transfers, reinstatements, and new assignments have been made in the U. S. Public Health Service during the month of January, 1930:

Transfers: to Louisville, Ky., Winnie Stinson; to Baltimore, Md., Mary Flippo; to Savannah, Ga., Sara Boynton, Mattie Johnson; to San Francisco, Calif., Katherine Kolkmeyer; to Norfolk, Va., Mary Haslip; to Fort Stanton, N. M., Daisy Cotey.

Reinstatements: Frances Curry, Flora Lambert, Emma Stafford.

New assignments: Eight.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

Nursing Service, U. S. Veterans' Bureau

The U. S. Veterans' Hospital, Alexandria, La., has been formally opened for the reception of patients. This hospital is for the care and treatment of general medical and surgical cases.

The postgraduate course in neuropsychiatric nursing recently established by the Bureau at U. S. Veterans' Hospital, Bronx, N. Y., exemplifies supreme advancement in mental nursing. It is of outstanding importance to the nursing personnel of the Bureau. One of the distinguishing features of the course is the carefully planned harmony of every detail of instruction. During the past month, Mary A. Hickey, Superintendent of Nurses, made an official visit to the Bronx Hospital, to supervise the nursing activities and the inauguration of the new system of nursing staff education.

During the month of January, 1930, the following named nurses were reinstated: Vera Yarbrough, Ellen Holt, Evelyn Ouellette, Marie Yeaman, Helene Baker, Patricia Noonan, Olive Sweet, Norma Lockstaedt, Marguerite Bruesehaber, Anna DeVore, Lillian W. Hayne, Mary A. Prince, Elizabeth Balton, Mary A. Johnson, Blanche Newsom, Gladys Brown.

Thirty-three new assignments were made and the following have been separated from the Service: Kathryne E. Adams, Ann S. Benguss, Nora T. Burke, Winifred M. Byrne, Gertrude Duchea, Evelyn Everman, Mary J. Green, Walter J. Lewis, Harriett E. Luther, Lillian M. Martin, Margaret McCloskey (death), Florence Olander, Bessie B. Sorsby, Elaine M. Sternagel, Mae Swanson, Mildred Thornton, Sara Vanderford, Helen C. Wailes, Elizabeth Wabaunsee, Jessie M. Wilson.

On January 28, 1930, the Superintendent of Nurses gave an address at the meeting of the Maryland State Nurses' Association, on the educational program of the Bureau.

The eleventh conference of the U. S. Veterans' Bureau Medical Council will be held in Washington, D. C., on March 6 and 8, 1930; The U. S. Veterans' Bureau Advisory Committee of Nurses will meet on the same date.

MARY A. HICKEY,
Superintendent of Nurses.

U. S. Indian Service

Appointments: Four.

Separations: Five.

Transfers: To Espanola, N. M., Ruth I. Riss; from nurse in the Indian Service at large to head nurse, Chilocco, Okla., Mrs. Jessie L. Gilham.

ELINOR D. GREGG,
Supervisor of Nurses.

U. S. Civil Service Commission

The United States Civil Service Commission announces the following open competitive examinations: Chief Nurse (Indian Service), Head Nurse (Indian Service), Graduate Nurse (various services), Graduate Nurse, Visiting Duty (various services), Graduate Nurse, Junior Grade (various services).

Applications for the abovenamed positions must be on file with the Civil Service Commission at Washington, D. C., not later than June 30.

On account of the needs of the Service, papers will be rated as received and certification made as the needs of the service required.

Competitors will not be required to report for examination at any place, but will be rated on their education, training, and experience.

Full information may be obtained from the United States Civil Service Commission, Washington, D. C., or from the Secretary of the United States Civil Service Board of Examiners at the post office or customhouse in any city.

International Catholic Federation of Nurses

The Sixth Annual Convention of the International Catholic Federation of Nurses will be held at Milwaukee, June 6, 7 and 8.

[illegible]es and Special Courses

[illegible]: The California League of [illegible] Education, northern branch, held an [illegible] on January 7 and 8 in the Audi[illegible] of the Stanford School of Nursing, San [illegible]. The first session commenced at [illegible], Pearl Castile, President of the [illegible] League, presiding. In the opening address, [illegible] Bailey, Ph.D., Associate Professor of Education, University of California, [illegible] the "Essential Factors in [illegible] Clinical Teaching"; of these the [illegible] might be considered: (1) A [illegible] of the purpose of teaching. The [illegible] be understood by both instructor and student. (2) An acceptance of the [illegible] involved. (3) Available teaching [illegible]. A real situation is better than an [illegible]. (4) Relationship of practical [illegible] taught. Work should be [illegible] the technic used in the classroom may be [illegible] to the wards. (5) Contrast the [illegible] a background of the normal [illegible] in health.

[illegible] the paper given by Dr. Bailey [illegible] of the Value of Clinical Teaching [illegible] the Viewpoint of The Hospital [illegible]; The Practicing Physician; The [illegible] Duty Nurse; The Private Duty [illegible]; The Public Health Nurse. During the [illegible] period Dr. Bailey discussed the [illegible] clinical teaching and pointed out [illegible] for: (1) Providing a student [illegible]; (2) Clearly defined objectives; (3) [illegible] of material; (4) Flexibility [illegible]; (5) Provision for [illegible] reaction [illegible] by planning for tests, etc.; (6) [illegible] of what is learned with the daily [illegible]. "Focusing attention on Individual Differences." It was suggested that [illegible] points in a nurse's [illegible] that she is dealing with [illegible] rather than things, that each [illegible] differs from every other [illegible] may be measured as (1) [illegible] bodily equipment; (2) Differ[illegible] functions; (3) D[illegible] to ourselves, other [illegible] as a whole. Bodily types [illegible] along the same [illegible] bodily is [illegible]. The study [illegible] given by Miss Kelsey [illegible] emphasis was [illegible] of the patient [illegible] society. An [illegible] the [illegible] patient, influencing [illegible]. It was shown that, despite the unavoidable constant changing of nurses, a certain continuity might be maintained by (1) the coöperation of supervisors, (2) an established routine of procedure, (3) schedules, (4) detailed reports. "Characteristic differences in good and poor nursing." Reference was made to a study of 100 teachers reported as poor and 100 teachers reported as good, in which it was noted that almost invariably the good teachers followed one line of procedure while the poor ones followed the opposite. (Although the study refers to a group of school teachers it may well be considered applicable to instructors in schools of nursing.) The rating sheet was cited as a good teaching device, since it sets a definite standard to which the student may aim.

Illinois: Chicago.—An Institute for Lay Boards of Hospitals and Public Health Nursing Organizations was held on February 17, in the Palmer House. This was arranged by the Central Council for Nursing Education, with the following program:

Morning Session, opening remarks by Mrs. David Wilson Graham; "Education of the Nurse from the Point of View of Public Health Nursing," Edna L. Foley, Superintendent, Visiting Nurse Association of Chicago; "The Value of Experience in Hospital Social Service to the Student Nurse," Ruth Emerson, Director of Medical Social Service, University Clinics, University of Chicago; "Public Health Nursing—Indispensable and Economical for Everyone if Organized," Haven Emerson, M. D., Professor of Public Health Administration, Columbia University, New York.

The luncheon speaker was Willard C. Rappleye, M. D., New Haven, Conn.

Afternoon Session, "Proper Support of Nursing Education," Edwin R. Embree, President, Julius Rosenwald Fund, Chicago; "The University and Nursing Education," Clarence Stone Yoakum, Ph.D., Dean, College of Liberal Arts, Northwestern University, Evanston; Symposium—"Economics of Nursing Education and Nursing Service": From the Point of View of the Administrator of the Hospital. Paul H. Fesler, Superintendent, University Hospital, Minneapolis, Minnesota; From the Point of View of the Administrator of the School of Nursing, Laura R. Logan, Dean, Cook County Hospital School of Nursing.

At the dinner which was given by the Council on Medical Education and Hospitals of the American Medical Association and the Central Council for Nursing Education, the speaker was President Robert Maynard Hutchins of the University of Chicago.

Minnesota: Winona.—Courses in Hospital Administration conducted under the instruction of Carolyn E. Gray, Chairman of the League Committee on Nursing Education for Colleges and Universities, opened at the College of Saint Teresa, on January 20.

In addition to lay nurses from Iowa, Minnesota, West Virginia and the Philippine Islands enrolled for these courses, Sister students include representatives from the following communities: Grey Nuns of the Sacred Heart, Oak Lane, Pa.; Missionary Sisters, Servants of the Holy Ghost, Techny, Ill.; Sisters of Charity, Leavenworth, Kans.; Sisters of Charity, Mount Saint Joseph, O.; Sisters of the Holy Cross, Notre Dame, Ind.; Sisters of the Holy Humility of Mary, Lowelville, O.; Sisters of Mercy, Chicago Province; Sisters of Mercy, Saint Louis Province; Sisters of Saint Francis, Rochester, Minn.; Sisters of Saint Francis, Sylvania, O., and Sisters of the Sorrowful Mother, Milwaukee, Wis.

The courses in Hospital Administration are given as a part of the Combined Course in Nursing and Liberal Arts leading to the Degree of Bachelor of Science in Nursing. The certificate of registration for nurses and a diploma from an accredited high school are prerequisites for enrollment. Enrollment for these courses this year represents a one hundred per cent increase over that in 1929 when the courses were first introduced at the college.

New Jersey: Newark.—The Instructors' Section of the New Jersey League of Nursing Education arranged the program for the fifth annual institute held at the Nurses' Residence, Newark City Hospital, January 30 and 31. The central theme was "Health." The institute was well attended. Forty-six schools registered; 165 persons were present the first day and 125 the second.

Dr. Earl Snavely welcomed the group. He was followed by Jessie M. Murdock, President of the New Jersey League, who opened the institute. Ethel F. Murray, Advisory Nurse of the Ocean County Health Association, Lakewood, gave a most pleasing presentation of "Teaching Health in Other Schools." Elizabeth F. Miller, Director of the Lincoln School of Nursing, New York, closed the morning session with an enthusiastic talk on "The Opportunities for Teaching Health by Private Duty Nurses."

On Thursday afternoon, Dr. Marcus A. Curry, Superintendent of the New Jersey State Hospital at Greystone Park, spoke on "Mental Health." He gave these questions as guideposts to an indication of one's mental health: What is your attitude toward reality? What is your emotional tone? How do you adjust to a group? Elizabeth J. Higbid, Instructor of Nurses, Hackensack, spoke on "The Uniform and Its Relationship to Health." In connection with this, there was an exhibit of dolls, dressed in the uniforms of over forty New Jersey schools of nursing. It created much interest. Dr. C. Ward Crampton, Chairman of the Committee on Periodical Health Examinations, Medical Society of the State of New York, spoke on "The Value of Periodical Examinations," stressing synthetic diagnosis, the value of posture, that colds are an evidence of neglect, and that abnormal conditions should be remedied at once. The Thursday program was brought to a close by Dr. George O'Hanlon, Medical Director of the Jersey City Hospital, who gave a paper on "The Value of a Health Program for Schools of Nursing," citing the importance of a definite program.

On Friday morning, "The Rôle of the Dietition in the Program of Health Teaching in Schools of Nursing" was presented by Elisabeth Miller, Instructor of Dietetics, Philadelphia General Hospital. She feels that the dietition has a heavy responsibility not only for food, but for healthful eating habits among student nurses. Jessie M. Murdock, Jersey City Hospital School of Nursing, gave the meaning and value of "Discipline in Its Relationship to the Health of the Student Nurse." Mary E. Pillsbury, Director of the Jewish Hospital School of Nursing, Brooklyn, N. Y., followed with an interesting talk on "Prophylactic Nursing." Reverend John G. Martin, Superintendent, Hospital of St. Barnabas, Newark, brought the third session to a close by a short address on "Spiritual Health."

The Friday afternoon session was under the auspices of the New Jersey Tuberculosis Association, conducted by Philip P. Jacobs, National Tuberculosis Association, Dr. B. S. Pollak, Hudson County Tuberculosis Hospital, Secaucus, and Violet Hodgson, Assistant Director, National Organization for Public Health Nursing, who presented a symposium on "Tuberculosis."

On Friday evening the mid-winter meeting of the New Jersey League of Nursing Education was held. Professor William van de Wall of Teachers College and of the Bureau of Mental Health, Pennsylvania State Welfare Department, gave a most enjoyable talk on "Music as a Health Agent," following this by a demonstration. Students from [illegible] different schools of nursing were gathered, and in a very short time they were presenting an impromptu program of songs, readings, violin and piano

[illegible]. Professor van de Wall emphasised the need for extra-curricular interests, and placed some responsibility upon the school for making it possible for the student to develop her talents.

New York: Plattsburgh.—An institute arranged by nurses from the Champlain Valley and the Physicians' Hospital was held on December 3, and was most successful, nurses coming from other parts of District 8 to attend it, the total attendance, seventy-five.

Morning Session, Champlain Valley Hospital, Reverend Sister Mary presiding. Opening remarks, L. Leda Boire, President Champlain Valley Hospital Alumnae Association; address of welcome and paper on "Rôle of Focal Infection in Diseases of the Eye," Dr. A. S. Schneider, President Clinton County Medical Society; Basal Metabolism; "Diabetes Diet and the Use of Insulin," Leo F. [illegible], Health Officer; "Diet in Disease," [illegible] Wilson; "Diagnostic Aids in Upper Abdominal Lesions," R. S. Macdonald, M.D.

Afternoon Session, Physicians Hospital, Mrs. F. C. Pomeroy, Superintendent of Physicians Hospital, presiding. "Blood Pressure," Dr. H. A. Houghton; "Local Spinal and Rectal Anesthesia," Dr. L. G. Barton, Sr.; "Medical Treatment through the Ages," Dr. W. H. Ladue; "Toxemias of Pregnancy," Dr. Barton, Jr.

Texas: The summer school at the University of Texas will be held from July 17 to August 31.

State Boards of Examiners

Arizona: The ARIZONA STATE BOARD OF NURSE EXAMINERS held meetings at the State House, Phoenix, January 3 and 4, when the following officers were elected: President, [illegible] Hutchison, Tombstone; secretary-treasurer, Minnie C. Benson, Tucson.

Colorado: The COLORADO STATE BOARD OF NURSE EXAMINERS will hold an examination in the State Capitol Building, Denver, on [illegible] and 28. For further information apply to [illegible] Murchison, Secretary, Capitol Building, Denver.

[illegible]: The next examination of the [illegible] NURSES' BOARD OF EXAMINERS [illegible] New Orleans and in Shreveport, [illegible]. For further information, address [illegible], Secretary, 1006 Pere Marquette Building, New Orleans.

Michigan: The MICHIGAN BOARD OF REGISTRATION OF NURSES will hold an examination for graduate nurses in Lansing, March 13 and 14, and one in Detroit, March 27 and 28. An examination for trained attendants will be held on the same dates.

Minnesota: THE MINNESOTA STATE BOARD OF EXAMINERS OF NURSES will hold examinations on Monday and Tuesday, April 14 and 15, beginning at 9:00 a.m., in: St. Paul, at the New State Capitol; Duluth, at St. Mary's Hospital; Rochester, at St. Mary's Hospital; Crookston, at St. Vincent's Hospital. Applications accompanied by the fee of $15 must be in the hands of the Secretary, Leila Halverson, 207 Old State Capitol, St. Paul, March 24.

North Carolina: The NORTH CAROLINA BOARD OF NURSE EXAMINERS will hold examinations in Raleigh, April 8, 9, and 10. All applications must be filed with the Secretary, Mrs. Z. V. Conyers, Box 1307, Greensboro, by March 29.

North Dakota: Examinations for registration of nurses in NORTH DAKOTA will be held April 8–9, in Grand Forks. For further information, address M. Clark, Secretary, Devils Lake.

Oregon: The OREGON STATE BOARD FOR EXAMINATION AND REGISTRATION OF NURSES will conduct an examination for applicants desiring to register, in Portland, on April 24 and 25. No applications will be accepted after April 14. For further information write Grace L. Taylor, Secretary, 448 Center Street, Salem.

Pennsylvania: The PENNSYLVANIA STATE BOARD OF EXAMINERS FOR REGISTRATION OF NURSES will conduct examinations in the following cities: Philadelphia, Harrisburg, and Pittsburgh, March 29; Philadelphia, Harrisburg, Wilkes-Barre, and Pittsburgh, June 7.

It is requested that applications be filed promptly with the Secretary of the Board, 306 Claster Building, Harrisburg.

Nurses in Pennsylvania are reminded that on and after September 1, 1930, it will be necessary for all applicants for examination to present evidence of the successful completion of one year of approved high school work as evaluated by the Bureau of Credentials of the Department of Public Instruction, Harrisburg. In order to take care of nurses not possessing such credentials, who have in the past failed to apply for registration, the Board is conducting extra examinations, the last

one of which will be given some time during the month of August. Since the credentials of the older graduates and frequently to be verified from different sources, thus entailing much correspondence, it is advised that such applications be filed at the earliest possible date. Mrs. Helene S. Herrmann, Secretary-Treasurer.

West Virginia: Henry M. Hall, M.D., of Wheeling has been made President of the West Virginia Board of Examiners for Registered Nurses, filling the vacancy caused by the death of Dr. Hupp.

State Associations

Arizona: The annual convention of the Arizona State Nurses' Association will be held in Douglas, April 11 and 12. The members of District 3 will be the hostesses, and as the District has only thirteen members, this is felt to be quite an undertaking. Only three meetings a year are held, as some of the members have to travel fifty miles to attend one. Meetings are held in Douglas, Bisbee, and Tombstone.

California: The Private Duty Section held two mid-year conferences on the same day in January, one in Oakland and one in Long Beach. The program was the same in both places and attracted a number of private nurses who discussed the problems incident to the adjustment of hours of duty, fees, etc., to the changing order of nursing. Two papers were read, one on "Thoracic Surgery," another on "Private Duty Nursing." A well filled question box indicated much thinking on every-day matters of concern to private nurses. At a charming luncheon in Oakland, at the Women's City Club, 158 nurses included the President of the Club, the President of the State Association, [illegible] of schools, public health nurses all of whom participated in the generous hospitality of the Northern Section of the Northern Branch of the League.

Connecticut: The Graduate Nurses' Association of Connecticut held its annual meeting, February [illegible], in Bridgeport, [illegible] with the [illegible] McGinnis, Chairman. After the [illegible] session, Mrs. W. A. Hart, [illegible] of the State Board of [illegible] for Nurses, gave a brief [illegible] of the Board in the [illegible] of nurses by [illegible] waiver and by reciprocity. [illegible] nurses have been registered since the compulsory registration law was passed in 1929. Worcester Warren, Superintendent of Bridgeport Schools, gave a most interesting talk on "What Can the Public Schools Do for the Nursing Profession?" He paid tribute to Mrs. Hart for her work at the high schools in Bridgeport. He is quite sure that much work can be done in the high schools through vocational guidance, and that it is not too early to begin with the eighth-grade pupil. Priscilla Humphreys, Instructor of Principles and Practice of Nursing, Yale School of Nursing, gave a paper on the methods applied at the Yale School. A comparison of hours of practice work at Yale School with other schools was very interesting.

At the afternoon session, Everett Cortwright, President, Junior College of Connecticut, gave as the title of his paper "This and That in Nursing Education." He had solicited data from several schools of nursing in and about New England which presented a picture not altogether pleasing but which gave food for thought. The speaker is quite sure that schools of nursing are entitled to aid for educational work the same as other schools and colleges. Amelia Grant, Director of Nursing, New York City Health Department, gave a most interesting talk which showed that training schools have much to do in the instruction of public health for students. Child and mental hygiene is greatly needed in our schools. The community has a right to look to us as public educators.

The speaker at the evening session was Dr. C.-E. A. Winslow on the "Work of the Committee on the Grading of Nursing Schools." Dr. Winslow gave everyone present further enthusiasm about this project.

The annual meeting of the Public Health Section was held on February 6. Louise [illegible], Chairman of the Section, welcomed the group. After the routine business, Florence Wright, Superintendent of Waterbury Visiting Nurse Association, gave a paper on "[illegible]." She [illegible] [illegible] by a [illegible] One [illegible]

At [illegible] of [illegible] that [illegible] in [illegible]

[illegible], was the long continued drought [illegible] of last summer, but she asked [illegible] to relax their vigilance next year. [illegible] Hammer, President of the Board [illegible] Organization, gave a review of the [illegible]. The Board Members' Organization will continue to hold its meetings at the [illegible] as the Graduate Nurses Association. [illegible] Violet Hodgson, Assistant Director of the National Organization for Public Health Nursing, spoke on "Why the Nurse in Industry." She stressed the point of educating the entire family in good hygienic habits, and [illegible] that the nurse in industry is the [illegible] can best educate the father. The health of the family should be the concern of the [illegible] nurse just as the health of the family is the concern of every other public health worker.

The Private Duty Section meeting, with [illegible], Chairman, presiding, was held [illegible]. The speaker for the morning was Dr. [illegible] P. Griffin of Bridgeport, who read an excellent paper on "Mental Hygiene for the Private Duty Nurse."

At the afternoon session, a paper on "Better Cooperation Between Private Duty Nurses and the Hospital" was read by Mary Addington [illegible] Haven and one by Lucy Beal, Director of Nursing, Waterbury Hospital.

The banquet was held Thursday night with an attendance of 184. The special feature was a "[illegible] Meeting" put on by the Board of Directors. The Graduate Nurses' Association [illegible] as their guests at the banquet, a [illegible] from each of the training schools [illegible] Bridgeport.

The [illegible] session of the Association was held [illegible] the reports of the committees [illegible] interesting. It was brought out [illegible] contributions to the Relief Fund [illegible] Association in 1930 were [illegible] Memorial Fund, [illegible] Loan Fund, $406.50, and [illegible] Memorial Fund, [illegible] Executive Secretary's report [illegible] work at Connecticut Head[illegible] to increase. A large number [illegible] in Connecticut, but [illegible] of their nursing organization [illegible] is getting in touch [illegible] and getting them to join. [illegible] as a result of Head[illegible] executive secretary [illegible], all working [illegible] years, there is a [illegible] publicity; [illegible] of Nursing [illegible] to the [illegible] the Relief Fund and the other funds have increased and there is a much better understanding between alumnae and state associations. However, there is much to be done, and the Executive Secretary gave suggestions to the sections regarding the collection of material and studies, the findings from which would be helpful to all nurses in Connecticut. The speaker for the morning session was Mary M. Roberts, Editor of the *American Journal of Nursing*, who took as her subject, "Trends in Nursing." Miss Roberts gave much about which to think. She spoke of the three important committees now at work in which nurses are interested: the Committee on the Grading of Nursing Schools, the Hoover Committee for the better care of children, officially known as the White House Conference, and the Committee on the Cost of Medical Care. She emphasized what a Nurses' Registry must be if it is to function to its highest capacity and give the community adequate service. She commended public health nurses for their readiness and open-mindedness to grasp every opportunity for advancement both for the profession and for their work. The same open-mindedness is not as apparent in some other groups. Miss Roberts emphasized the need of every nurse belonging to her alumnae, state and national associations. Being a nurse is not enough; she must be a nurse who will endeavor in every way possible to make herself worthy of the confidence placed in her and she should be as good a nurse as people and students believe her to be. About fifty girls from the schools of Bridgeport, who are interested in nursing and who are students in the eighth grades and first-year high, were the guests at the morning meeting, coming especially to hear Miss Roberts. As far as is known, this is the first time in Connecticut that vocational guidance in the public schools has made arrangements for the girls interested in nursing to attend a meeting of the Graduate Nurses' Association.

In the afternoon, J. Beatrice Bowman, Superintendent Navy Nurse Corps, gave a splendid illustrated talk on the "Medical and Nursing Activities in the United States Navy."

The attendance the first day was 201; the second day, 336; and the third day, 236; making a total attendance of 773. Miss Barrett, the retiring President, was given a rising vote of thanks for the very valuable contribution she has made to nursing progress during her three years of presidency. Tea was served each afternoon following the meeting. The first day, by Bridgeport Hospital Alumnae Association; the second day, by St. Vincent's Hospital Alumnae Association; and the third

day, by the Visiting Nurse Association of Bridgeport.

The following officers were elected in the G. N. A. and its sections:

Graduate Nurses' Association of Connecticut—President, Irene V. Muller, Hartford; vice presidents, Sarah E. Hyde, Middletown, Norma White, New Haven, Laura Brownell, Hartford; secretary, A. Lillian Forbush, Middletown; treasurer, Mabel Macdonnell, Stamford; directors, Mary Grace Hills, A. Elizabeth Bigelow, Mrs. Winifred Brennan, Louise B. Johnson, Margaret J. Barrett, Rachel McConnell.

Educational Section—Chairman, Maud E. Traver, New Britain; vice chairman, Mrs. Winifred A. Hart, Bridgeport; secretary, Grace Andlow, Norwich; councillors, Effie J. Taylor, Emmeline K. Mills, Rachel McConnell.

Private Duty Section—Chairman, Ethel Peck, Bridgeport; vice chairman, Alice H. Tiers, Winsted; secretary, May Sabin, Hartford; councillors, Helen Bray, Mrs. Jean Hooker, Margaret Gallagher, Helen Coughlin, Nell Burns, Anne Kiely.

Public Health Nursing Section—Chairman, Florence Whipple, Waterbury; vice chairman, Harriet Parker, Torrington; secretary-treasurer, Ethel Biggs, East Hartford; councillors, Grace Platt, Marjorie Webster, Ethel Ericson, Rachel Colby, Jeanette Van Coevering.

Delaware: The annual meeting of the Delaware State Association of Graduate Nurses was held January 23, at the Delaware Hospital, Wilmington. Reports were given from each alumnae association and from the President, Evelyn Hayes, who also gave a résumé of the International Congress in Montreal. Officers elected are: President, Evelyn B. Hayes; vice presidents, Mrs. Helen T. Whitehart, Caroline Sparrow; secretary, Mrs. Esther W. Petticord; treasurer, Tacie Matthews.

Georgia: The Georgia Hospital Association will meet in Augusta, May 12. Beginning this year, it becomes a Geographical Section of the American Hospital Association, its membership carrying membership in the A. H. A. without payment of additional dues.

Maryland: The twenty-seventh annual meeting of the Maryland State Nurses' Association, in joint session with the Maryland League of Nursing Education and the Maryland State Association for Public Health Nursing, was held in Baltimore, January 28, 29, 30. An appeal for a good attendance was sent out with the programs and, in spite of the inclement weather, all of the meetings were well attended. At the request of a group of nurses, there were no morning sessions, and this arrangement proved entirely satisfactory, as was evidenced at the evening meeting on Tuesday, when 400 nurses were present.

The meeting on Tuesday afternoon was held under the auspices of the Maryland State Nurses' Association, Jane E. Nash, President, presiding. Miss Nash, in her annual address said: "It seems to me that for the coming year, the most important piece of work for our Association is to coöperate with the Alumnae Associations in stimulating a greater interest on the part of each graduate nurse, both in her own work and a better understanding of the help that her Association can give her. Group nursing, industrial nursing, hourly nursing, etc., will engage many graduate nurses in the next few years in Maryland, but only those nurses will be successful who are actively interested and desirous of giving service of the highest order."

The Secretary's report showed an increase of membership, and also stated that, as a result of a visit in October from Dora M. Cornelisen, Field Representative of the *American Journal of Nursing*, subscribers to the *Journal* had increased in a few months from 292 to 572. Following a custom for several years, tea was served by St. Barnabas Guild after this session.

The meeting on Tuesday evening was held under the auspices of the Maryland League of Nursing Education, Maud M. Gardner, President, presiding. At this session, "The Harvey Tercentenary Film" was exhibited through the courtesy of the Welch Library; accompanied by remarks by Dr. Louis P. Hamburger, this proved to be one of the most enjoyable and interesting features of the Annual Meeting. Mary A. Hickey, Superintendent of Nurses, United States Veterans' Bureau, spoke that same evening on the "Educational Program for Nurses of the Veterans' Bureau."

On Wednesday, the meetings were held under the auspices of the Maryland State Association for Public Health Nursing, Mrs. Ethel [illegible] Day, President, presiding. Preceding the luncheon meeting, Evelyn Davis, State Public Health [illegible] in New York, gave an interesting paper, "Lay [illegible]."

In the evening, after a short business session Dr. Walter N. Thayer, Commissioner of Prisons, who has recently been appointed in the State of Maryland, gave a very interesting talk about his work among the prisoners.

[illegible] afternoon session on Thursday, [illegible] Crisman, graduate of the Union [illegible] Hospital, conducted a very in[illegible] demonstration of nursing procedures [illegible] auspices of the Maryland League of [illegible] Education.

[illegible] closed with a delightful well-[illegible] dinner at the Emerson Hotel. The [illegible] were disappointed in not having [illegible] with them, as was announced on [illegible], but they understood her reason [illegible] the dinner. Miss Nash pre-[illegible] introduced Miss Lawler, who in [illegible] the speaker of the occasion, [illegible], recently returned to this [illegible] Siam. The nurses gave Miss [illegible] a hearty welcome and sounded a [illegible] appreciation for her most enjoyable [illegible] "Some Eastern Experiences in Nursing." [illegible] guests were Mary L. Nice, [illegible], Frederick City Hospital, and [illegible] Wise, Superintendent Peninsula [illegible], who have rendered long and [illegible] service not only in their respective [illegible], but in the communities where they [illegible]. Officers for the coming year are: [illegible] E. Nash; vice presidents, Elsie [illegible], Martha E. Friend; secretary, [illegible]; treasurer, Anna L. Zerhusen; [illegible] Mrs. Ethel Monroe Troy, Hester I. [illegible].

[illegible]: The NEW JERSEY STATE [illegible] ASSOCIATION will hold its annual [illegible] Elizabeth, April 10–12, at the Win[illegible] Hotel.

[illegible]: The OHIO STATE NURSES' ASSOCIA[illegible] hold its annual meeting in Lima, [illegible]. Headquarters will be at the [illegible], and general sessions will be [illegible] Auditorium.

[illegible]: The RHODE ISLAND STATE [illegible] held its annual meeting [illegible] at the Medical Library, Janu[illegible] of officers and committees [illegible] the address of the President, [illegible]. It was voted to give [illegible] Hampton Robb Schol[illegible] Loan Fund, the [illegible] the new women's prison at [illegible] and the General Federation [illegible]. Miss Fitzpatrick spoke [illegible] committee, and a [illegible] "Maternity" was [illegible]. Officers elected [illegible], Providence; [illegible] F. [illegible], [illegible] Goodnow, Newport; [illegible] L. M. Belle Avery, Providence; corresponding secretary, Mrs. Helen G. Batchelder, Providence; treasurer, Mrs. Christy B. Oliver.

At the annual meeting of the RHODE ISLAND LEAGUE OF NURSING EDUCATION, held January 30, the following officers were elected: President, Helen O. Potter, Providence; treasurer, Margaret Daley, Providence; directors, Sarah C. Barry, Sara A. Carroll.

The speaker of the afternoon was Dr. Paul J. Ewerhardt, Director of the Mental Hygiene Center of Providence, whose topic was "Child Guidance." He also stressed most earnestly the need of mental training for all nurses.

Washington: The WASHINGTON LEAGUE OF NURSING EDUCATION held its January meeting at the Providence Hospital, Seattle. There was a splendid attendance. Following a brief business meeting, Henrietta Adams, of the University of Washington, led an interesting discussion on state laws regarding nursing.

District and Alumnae News

Alabama: Birmingham.—The annual meeting of ST. VINCENT'S HOSPITAL ALUMNAE ASSOCIATION was held in the Nurses' Home, January 15. Routine business was transacted, while the tellers were counting the ballots. Sister Alphonsine gave a very encouraging talk, and wished for all the members a very prosperous year. Miss Moultis gave a brief outline of the work accomplished in the past year, and offered a few suggestions for the coming year. The following officers were elected: President, Catherine Moultis; vice presidents, Mrs. Mae Thomas, K. Jackson; secretary, Mrs. D. C. Van Merkstyne; treasurer, Fannie Bell. After a lively discussion of means to raise money for the Club House, dances and card parties were decided on.

Connecticut: New Haven.—Mary Grace Hills, who has been Superintendent of the Visiting Nurse Association since it was organized, has resigned, after a service of twenty-five years.

Illinois: Chicago.—The annual meeting of the FIRST DISTRICT was held on February 11, at the Chicago Woman's Club, with afternoon and evening sessions, at both of which there was a gratifying attendance. The President, Ella G. Best, presided. The afternoon meeting was given to business and reports. An outstanding feature was the President's address. Ellen D. Nicholson gave an interesting

talk on Persia, where she has been administering a school of nursing.

At the evening session, Dr. Carl A. Hedblom gave a talk on "Cancer." Officers elected are: First vice president, Anna D. Wolf; third vice president, May D. Collier; secretary, Ethel Olson; and seven directors.

The Chicago Babies' Nurses' Club raised funds for providing Christmas cheer for tuberculous women in several institutions by means of "patch aprons." Club members and friends received aprons with patches partly sewed on. Contributions were sewed in under the patches. By this means, $127 was raised. The club members represent fifteen different hospitals. Decatur.—May 3 will be the tenth anniversary of the Decatur and Macon County Hospital Alumnae, which was organized with twenty members and now has eighty. At each meeting a professional problem or some phase of nursing is discussed by four nurses, the schedule for the year being posted in the training school office. "The Lamp [illegible]," a pageant which is the history of nursing, will be given by fifty members on May 6, in the auditorium of James Millikin University.

Georgia: Rome.—At the annual meeting of the Seventh District, held in January, officers were elected: President, Shirley Hendrick; vice presidents, Leslie Atkinson and Mrs. G. D. Young; secretary, Mrs. E. P. Grant; treasurer, Mrs. Claude Taylor. McCall Hospital Alumnae Association held a meeting, January 18, with good attendance. A committee was appointed to arrange programs for the year, and the superintendent of the hospital gave a talk on the nursing points discussed in the open forum program of the College of Surgeons' meeting held in Atlanta. The Alumnae Association is following the work of the Grading Plan with much interest. Savannah.—The First District held an enthusiastic meeting on the evening of January 28, at Oglethorpe Sanatorium. Thirty members were present, Martha Clemons, President, presiding. The Treasurer's report showed a balance of $[illegible]. The Public Health Section reported [illegible] public health nurses in the district [illegible]. A total of $[illegible] was contributed by the District Association and [illegible] to the Nursing Unit of the [illegible] Hospital building fund. The District voted to contribute 25 cents per capita to the Grading Plan.

Maine: Augusta.—The Central District Association held its annual meeting on January 25, Miss Rowell presiding. At the morning session, Abbie Dunn gave an interesting account of her work with school children; Alice Wessels spoke on "Teaching Case Methods in Schools of Nursing," and Frances [illegible], a student, gave a demonstration of a case study of pernicious anemia. At the afternoon session, business was transacted and the following officers were elected: President, Margaret [illegible], Augusta; vice presidents, Katherine Keating and Elizabeth O'Connor, Lewiston; secretary, Nora Rowell, Lewiston; treasurer, [illegible], Augusta. At noon, a luncheon was given at the Augusta General Hospital. Portland.—The Alumnae Association of the Children's Hospital held its annual meeting and banquet at the Lafayette Hotel, January 14. The following officers were elected: President, Edna Reynolds; vice presidents, Mrs. Stella Poirier, Stephanie Ward; secretary, Helen Lord; treasurer, Dorothy Murphy.

Massachusetts: Boston.—The fifty-ninth semi-annual business meeting of the Children's Hospital Nurses' Alumnae Association was held at the Nurses' Home, January 13, with twenty-four members present. The following officers were elected: president, [illegible]; vice president, Frances Clyde; secretary, Virginia J. W. [illegible]; treasurer, Catherine Watkins. Natick.—The Leonard Morse Hospital Nurses' Alumnae Association met at the home of Mrs. Dana Cummings, February 3, with a good attendance. Miss [illegible], Superintendent of the Hospital, spoke on the activities of the nursing organizations. Pittsfield.—The alumnae of St. Luke's Hospital, at their annual meeting, on January 23, elected the following officers: President, Mary [illegible]; vice presidents, [illegible], Margaret [illegible]; secretary, Mrs. A. B. [illegible]; treasurer, Mary [illegible]; counselor, Elizabeth O'Brien. Committee chairmen are: [illegible], Harriet [illegible]; [illegible]. The [illegible] was admitted [illegible] Association. [illegible]

[illegible] annual meeting of the [illegible] was held [illegible] Lodge.

[illegible] Reports were given and officers [illegible] president, Josephine Nichols; vice [illegible] Mrs. Amelia McLaughlin; record- [illegible] Clara Gamer; corresponding [illegible] Ruth Strain; treasurer, Grace [illegible] and two directors. Detroit.— [illegible] 7, Lucy Minnigerode addressed [illegible] of nurses on the organization of [illegible] Public Health Service. The meet- [illegible] in the Nurses' Club. Katharine [illegible] been appointed to the faculty of [illegible] College for the purpose of develop- [illegible] of Public Health Nursing. [illegible] The Lansing District met on [illegible] at the home of Mrs. L. C. Ludlum [illegible] of considering methods of [illegible] for the establishment of a central [illegible].—The Traverse City [illegible] meeting, followed by a tea, was held at [illegible] Hospital, on the afternoon of Feb- [illegible] Long distances and bad roads have [illegible] handicap to this District, [illegible] nurses having to drive seventy [illegible] meetings. Saginaw.—The [illegible] District is organizing a central [illegible] nurses. St. Joseph.—The St. [illegible] Association met at dinner [illegible] Hotel, on the evening of [illegible]. Plans are under way for a mem- [illegible].

[illegible]: St. Paul.—Elizabeth M. Rey- [illegible] Bessie Baker as Superin- [illegible] at the Charles T. Miller [illegible] Reynolds is a graduate of the [illegible] Hospital, Baltimore, Md. [illegible] B.S. degree from Columbia Uni- [illegible] held several executive posi- [illegible] being at the Ithaca Memorial [illegible], N. Y.

[illegible] St. Joseph.—Helen Reese is in [illegible] hospital of Armour and Co., [illegible] Jane Fairfax, who resigned [illegible] St. Louis.—At the last meet- [illegible] League of Nursing [illegible] following officers were elected: [illegible] Cooper; vice president, [illegible]; secretary, Margaret [illegible]

[illegible] Laconia.—On January [illegible], President of Laconia [illegible] gave a most interesting [illegible] the [illegible] of the hospital in 1888 [illegible] to the present time. [illegible] quarterly meeting [illegible] was held. The [illegible] to send a letter of [illegible] to Linda Richards, first graduate nurse of America. The reply which came back would seem characteristic: "I only did the best I knew." Mr. Perkins gave realization to the fact that Laconia has a certain distinction in the nursing world. It has as residents Miss Lucy Drown and her sister, Mrs. Mary Drake, pupils of Miss Richards, the former of whom was for twenty-five years superintendent of nurses at Boston City Hospital. Laconia was also for over twenty years the home and is now the place of burial of Malenka O. Wood, second trained nurse of America. Miss Wood died in 1922. Miss Drown is an enthusiastic reader of the *Journal* and donates her copies for the files of the hospital classroom. Manchester.—The Elliot Hospital Alumnae Association held a meeting at the Y. W. C. A., on January 15, with a good attendance. Beatrice Dugan presided. It was voted to donate $25 to the Nurses' Relief Fund and $25 to the Y. W. C. A. Vernice Patersone gave a report of the December meeting of the State Association. Six new members were admitted.

The quarterly meeting of the Sacred Heart Hospital Alumnae Association was held January 30, at St. Ursula's Home for Nurses. Mrs. Durning Davis presided and there were twenty members present. Election of officers was held, and those elected for the coming year were as follows: President, Mrs. Durning Davis; vice president, Mary Stearns; treasurer, Ann Hayes; secretary, Beatrice Markey. Chairmen of committees are: Nominating, Ann Hallahan; Welfare, Margaret Cronin; Ways and Means, Ann Hayes.

Although the Association has not accomplished anything spectacular in the past year, the younger nurses immediately on graduating have become active members. At the conclusion of the year we had the largest State membership that we have ever had. In the coming year it is planned to have a few joint meetings with the training school and in that way arouse interest before graduation. Last year the graduates were entertained at a field day and the annual banquet.

New Jersey: East Orange.—The Alumnae Association of the Homeopathic Hospital of Essex County held its annual meeting at the Nurses' Residence, January 7, at which time the following officers were elected: President, Marie C. Leidig; vice president, Anna Short; recording secretary, Rebecca Cameron; corresponding secretary, Mrs. Mildred Farish; treasurer, Minnie Nagle. New Brunswick.—The annual meeting of District 4 was held at St. Peter's General Hospital on

February 4. Emma Collins, of the Official Registry of Brooklyn, N.Y., was present and gave a most interesting and instructive address on the "Official Registry." The officers for the year 1929 are as follows: President, Sarah Van [illegible], Perth Amboy; vice president, Martha [illegible] Watson, New Brunswick; secretary, [illegible], Long Branch; treasurer, Mrs. Margaret Brown, Spring Lake. Orange.—The Alumnae Association of the Orange Memorial Hospital held its annual meeting on January 22. The following officers were elected: President, Helen Stephens; vice president, Ruth Whitney; secretary, Mrs. Margaret B. Richards; treasurer, Grace V. Bailey; and three directors. In the new hospital which was opened in January, the Association has an endowed room. It has two beds, and has been used almost constantly. Passaic.—At the annual meeting of the Passaic General Hospital Alumnae Association, held February 5, the following were elected: President, Kathryn Coyne; vice president, Mrs. Margaret [illegible]; secretary, Margaret Speer; treasurer, Mrs. Ruth Stephenson.

New York: Newburgh.—The tenth annual meeting of District 11 was held at the Nurses' Home of St. Luke's Hospital, January 17. Officers were elected for the coming two-year term. There were fifty-six members, one guest, and two student nurses present. Three meetings were held during the year with an average attendance of fifty-seven members and seven students. The alumnae associations represented were those of St. Luke's Hospital, Newburgh; the Kingston City Hospital; the Middletown State Hospital; and the Benedictine Hospital at Kingston. During the year the following have been accomplished: Revision of the District constitution and by-laws to conform with the state requirements; the changing of the annual meeting and the meetings of the alumnae associations to the third week of January. The report on nurses' relief showed $154 contributed by the District during the year. Dues for membership in alumnae associations will now be [illegible] per capita; dues for individual members, [illegible]. The membership has increased considerably in most of the alumnae associations, and the individual membership now numbers [illegible], an increase of 24 this year, due almost entirely to the efforts of the [illegible] chairman, Mrs. Margaret Chapman. Mrs. Chapman has been untiring in her efforts to serve the District. On time off duty which might have been devoted to rest and recreation, she has visited all of the hospitals and institutions in the District, with the hope of interesting the nurses in joining the District Association, and securing subscriptions to the American Journal of Nursing. The members realize and appreciate very much, indeed, Mrs. Chapman's efforts for nursing interests in District 11. New York.—The New York League of Nursing Education held a most interesting and enjoyable meeting at Mt. Sinai Hospital, February 5. This was the third in the series on "The Improvement in Nursing Practice." Topics discussed were: "The Present Arrangement of the Course in Principles and Practice of Nursing at the Yale School," Priscilla Humphrey; "A Technic for Supervising Practical Procedures in a Special Department," Maud Kelley; "One Method of Correlating Practice and Theory," Anne Humphreys; "How Practical Nursing Fits into the Block System," Eleanor Lee.

The cornerstone of the new residence for nurses at St. Mark's Hospital, which is being rushed to completion, was laid February 8. The building will have nine floors, with provision for three additional when the growing needs of the hospital require them. The first floor is devoted to a large auditorium which will contain the [illegible] organ, a gift to the school. The second floor is the "social" floor with appropriate lounges, small parlors and an alumnae room. The third is the educational floor, devoted entirely to classrooms and laboratories. The remainder of the building is given over to dormitory space. Student rooms are all single. Each pair of head nurses' rooms will have a connecting bath, and five suites are planned for the officers of the school.

The Private Duty Section of District 13 held its first annual meeting on January 13. One special and five regular meetings have been held during the year, meeting places having been furnished by the alumnae associations of St. Luke's, New York, Mt. Sinai, Bellevue and Post-Graduate. The time of meeting is [illegible] p.m., on the second Monday in January, March, May, September, November. The March meeting will be held on the [illegible] at St. Luke's, and the May meeting on the [illegible] at the Post-Graduate. Officers for 1929 are: Chairman, [illegible]; vice chairman, [illegible]; secretary, Anna [illegible]; treasurer, [illegible]. A fund [illegible] from [illegible] New [illegible] Association. [illegible]

[illegible], President of the New York State League of Nursing Education, [illegible], President of St. Mark's Hospital, and Miss Elsie Maurer, Superintendent of [illegible], placing manuscripts in the cornerstone box of the Nurses' Home. (P. & A. Photo.)

[illegible] held its annual meeting [illegible] and elected: President, Helen [illegible] Mrs. Nellie Ross and [illegible] secretary, Loraine Hasse; [illegible] Elizabeth Hawkswell; and [illegible] The Rochester General [illegible] Association held its [illegible] January 6. The following [illegible] President, Katherine [illegible] and Rose [illegible] treasurer, [illegible]—The annual [illegible] held at the [illegible] with 96 members [illegible] officers were elected: [illegible] vice presidents, [illegible] secretary, [illegible] Sherwood; [illegible] The retiring president, Miss Finch, gave a résumé of the accomplishments of the District for the past two years. Membership has increased from 712 to 880; *Journal* subscriptions have been increased from 121 to 194; Nurses' Relief Fund subscriptions amounted to $807, which is one dollar per capita for the membership as of January 1, 1920; Red Cross memberships have been slightly increased, but not as much as was hoped for.

North Carolina: Asheville.—District 1 held its annual meeting on January 8. The secretary, in her annual report, stated that twelve regular, and two called meetings were held during the year, and showed that much systematic and constructive work had been accomplished. Two new members were accepted at this meeting, and an increase of 29

[illegible]

[illegible] Duty" was discussed. Cincin- [illegible] regular meeting of District 8 [illegible] at St. Mary's Hospital, February [illegible] B. Campbell gave a very inter- [illegible] on "Child Welfare in the Ameri- [illegible]." The Public Health Section [illegible] held its regular meeting Febru- [illegible] Emanuel Community House. [illegible] of the Personnel Department [illegible] and Suburban Bell Tele- [illegible] gave a very interesting talk. Co- [illegible] District 12 held its regular meeting [illegible] Hospital Nurses' Home, Feb- [illegible] The program was in charge of Ruth [illegible] a most interesting program was [illegible] which consisted of special features [illegible] by students from each Colum- [illegible] of Nursing. Youngstown.— [illegible] added 190 new nurses to its mem- [illegible] the year, making a total mem- [illegible] 486. Meetings were held in dif- [illegible] of the District, which extends [illegible] to the Ohio River, a distance of [illegible] All meetings were well attended, [illegible] at each meeting, due to the [illegible] worth-while programs presented. [illegible] president, Miss Brown, her prede- [illegible] Larimer, and Miss Roberts, [illegible] the *American Journal of Nursing*, [illegible] addressed a meeting during the [illegible] Hedberg, a graduate nurse from [illegible] and now a medical missionary to [illegible] home on furlough, was a guest [illegible] an evening meeting, which was [illegible]. Another program which was [illegible] stimulating was an "Alumnae [illegible] Each Alumnae was given ten [illegible] program, during which time [illegible] some facts and accomplish- [illegible] own organization or put on a [illegible] raised $300, its quota, for [illegible] Fund, by entertainments. [illegible] Practice, conducted [illegible] District members during the [illegible] have been found interesting [illegible]

[illegible]—A letter has been re- [illegible] Woodbury, class of 1919, [illegible] telling of her work as a [illegible] in Managua, Nicaragua. [illegible] she has opened the first [illegible] in the country.

[illegible]—On January 7, [illegible] Association of the [illegible] held its annual meeting, [illegible] elected: President, [illegible] secretary, Helen Balk; [illegible] Reeds. The annual [illegible] and committees showed progress—a membership of 106 was listed at the opening of the year. Scranton.—District 3 held its annual meeting, January 15, with an attendance of 131. The following officers were elected: President, Sarah H. Smith; vice presidents, Miss Wentzel and Jillian Kilgus; secretary, Sister Mary Avellino; treasurer, Miss Huff; and two directors. The next meeting will be held in the Wilkes-Barre General Hospital, Wilkes-Barre.

South Dakota: Mitchell.—The quarterly meeting of District 2 was held January 14. Two very instructive lectures were given, one on "Goitres" by Dr. Rober, and the other on "Diabetes" by Dr. J. H. Lloyd. Mabel Woods gave an interesting report of the Atlantic City Convention of the National League of Nursing Education which was followed by a short business meeting. The next quarterly meeting will be held at Sioux Falls.

Texas: Abilene.—The regular meeting of District 15 was held at the West Texas Baptist Sanitarium, January 16, for a luncheon and business meeting. A cash offering was taken for a sick member of the district. The new officers for 1930 are: President, Stella McCullough; secretary, Ellen D. Johnson.

Virginia: Richmond.—Dr. George E. Vincent, retiring president of the Rockefeller Foundation, will give the commencement address at the Medical College of Virginia, on June 3. At this time approximately 190 will be graduated from the schools of medicine, dentistry, pharmacy, and nursing.

Washington: Aberdeen.—The Eighth District held its annual meeting at the Nurses' Residence of the Hoquiam General Hospital, January 3. Satisfactory reports were made and election of officers took place. Bellingham.—The Visiting Nurse Association held its annual meeting January 31. Mrs. Elizabeth Soule of the Department of Nursing Education, University of Washington, was the speaker. The Association has enjoyed a most profitable year under the able direction of Mary Pritchard. Longview.—District 10 held its regular monthly meeting at the Longview Memorial Hospital January 7. Much time was devoted to a discussion of securing a central registry, this matter having been brought up at the suggestion of the hospital and the private duty group. Seattle.—District 2 met at the Swedish Hospital, February 3. Dr. J. F. LeCoque gave an interesting and instructive lecture on the "Uses and Advantages of Physical Therapy." Borghild

Jarvis, physical therapist, gave a demonstration of many of the points Dr. LeCocq brought up. Spokane.—District 4 devoted the February meeting to a discussion of the problems regarding the state bulletin. The quarterly meeting of the Washington Public Health Nurses' Association was at dinner, at the Y. W. C. A., on January 31. Matters of interest to public health nurses were discussed. Tacoma.—District 2 had a splendid January meeting with Valley Nelson, missionary nurse to China, now home on furlough, as the main speaker. Miss Nelson told of hospital and nursing conditions in her district, not far from Peking. Vancouver.—The St. Joseph's Hospital graduates held their initial meeting for a discussion on organization of an Alumnae Association in December, 1929. It was decided that on January 8, 1930, the first annual meeting should be held for adoption of a constitution and by-laws and election of officers. All nurses present showed great enthusiasm giving new impetus to working plans. The following officers were elected: President, Nan [illegible]; vice president, Mrs. Winifred White; secretary, [illegible]; treasurer, Grace Good. Meetings will be held the first Wednesday of each month.

Wyoming: Sheridan.—At a recent meeting of the graduate nurses of Sheridan and Buffalo and vicinity, District 3 was reorganized, consisting of Sheridan, Weston, Crook, Campbell, and Johnson counties. The following officers were elected: President, Pearl Summerford; vice president, Agnes Donovan; secretary, Marion Kent; treasurer, Mildred Weber; and three directors.

Too Late for Classification

Maine: The State of Maine Board of Registration and Examination of Nurses will hold an examination for applicants for registration the third Wednesday in April, the 16th and 17th, beginning at 9 a.m., at the State House, Augusta. Applications must be filed with the secretary, Mrs. Theresa R. Anderson, Box [illegible], Bangor, fifteen days previous to date of examination.

The semi-annual meeting of the Board of Nurse Examiners will be held at the State House, Augusta, the third Wednesday in April.

Deaths

[illegible] A. Cameron (class of [illegible], Elliot Hospital, Manchester, N. H.), on January 17, at the New Hampshire Memorial Hospital, Concord. Miss Cameron had filled, with unusual ability and sound judgment, almost every office of the Graduate Nurses' Association of New Hampshire and had been treasurer and a director of the New England Division of the American Nurses' Association from its organization to the time of her death. After her graduation she did private nursing in Manchester, where she was in much demand by physicians and patients because of her efficiency, her faithfulness, and good cheer. She was appointed a member of the Board of Nurse Examiners March 7, [illegible]; was made secretary of the Board, April 1, and Inspector of Training Schools for Nurses, October 1. She was one of the first Red Cross nurses in New Hampshire. Barred from overseas duty during the World War, by lack of vigorous health, she took over the superintendency of the New Hampshire Memorial Hospital, thus releasing the superintendent for active service in France. Her work for Hospital Training Schools for Nurses was invaluable. In coöperation with the National Association she raised the standards. Her advice and directions were just and of utmost value not only for each school, but individual nurses as well. In August, 1919, she became associated with the New Hampshire Board of Public Welfare as field agent for the placing of dependent children, and until the last few days of her life was an ardent worker, particularly for the well-being of children. Her life through all these years showed to the fullest extent courage over physical handicaps and an unusual loyalty and devotion to all her work. To know Miss Cameron well was to appreciate her high character and recognize her as a wise counsellor, faithful in service, loyal to her profession, a friend of the friendless.

The entire nursing profession of New Hampshire learned with deep sorrow of her death. Though far from well for many years, her going was a distinct shock, as she was about her regular duties until a few days previous. A noble specimen of womanhood. A great loss to the state of New Hampshire and the nursing profession. Simple funeral services were held at St. Paul's Church, Concord, N. H., attended by a large representative gathering of hospital superintendents and nurses from all parts of the state. Burial was at Woburn, Mass.

Hannah F. Clapp (class of [illegible], Boston City Hospital, Boston, Mass.), on December 1, 1929, at the Eastern Maine General Hospital, Bangor, Maine, after a short illness. Miss Clapp's death occurred on the [illegible] anniversary of her arrival at the Hospital,

[illegible] she held the position of Assistant Super-[illegible]. She was a member of the Maine [illegible] Board of Registration and Examination [illegible], and for eleven years was secretary [illegible] Maine State and Local Committee on [illegible] Nursing Service. For twenty-five [illegible] was a member of the Bangor festival [illegible]. Her devotion to duty, combined [illegible] kindliness and understanding, [illegible] an outstanding example for her as-[illegible] in the Hospital, who all feel that they [illegible] a personal loss.

[illegible] C. Farley (class of 1904, [illegible] City Hospital, and of 1905, Boston [illegible]), on January 6, at the home [illegible] in Auburn, N. H. Mrs. Farley [illegible] work. She served as head [illegible] instructor at the Boston City Hos-[illegible] superintendent of nurses at the [illegible] College Hospital, Brooklyn, N. Y., [illegible] Lying-in Hospital, Provi-[illegible]. She also spent several years in [illegible] Farm Convalescent Home, [illegible], N. Y., when her health broke [illegible]. She was also one of the oldest [illegible]. Mrs. Farley was loved and [illegible] by all.

[illegible] Jennings (class of 1902, Blessing [illegible], Ill.), on December 18, 1929, [illegible]. Miss Jennings had done private [illegible] in and near Quincy since her [illegible].

[illegible] Lord (class of 1897, Maryland [illegible] Hospital, Baltimore, Md.), on [illegible], at her home in Asheville, N. C., [illegible] of ten days from pneu-[illegible] her graduation Miss Lord re-[illegible] as Superintendent of [illegible] View Hospital for several years. [illegible] she returned to her home [illegible], N. C. Later she moved to [illegible] she became a very successful [illegible] private duty nurse. Owing [illegible] during the past few years [illegible] the active practice of nurs-[illegible] in the profession was un-[illegible] was a most loyal and devoted [illegible] Association, keenly in-[illegible], and gave liberally of [illegible] in its service. Her [illegible] personality, high professional [illegible] made her an [illegible]. In the death of Miss Lord the North Carolina Nurses' Association has suffered an irreparable loss.

Sara Elizabeth Nichols (graduate of Wesley Hospital School of Nursing, Chicago, Ill.), on January 7. Miss Nichols is the first of her class to pass on. She lived in Chicago continuously since 1901, doing private duty nursing part of the time. For two years she was night supervisor at Wesley Memorial Hospital. In 1912 she organized the Nurses' Registry, and diected it, until it combined with the Chicago Nurses' Registry in the spring of 1918, continuing her services with the combined institution until the day of her death. She had gone to her post of duty to take up her daily tasks when she passed to her eternal occupation. To be in Miss Nichols' presence was a benediction.

Harriet E. Parker (class of 1896, Protestant Episcopal Hospital in Philadelphia, Pa.), on January 15, at the Hospital, after an illness of several months. Miss Parker was engaged in active nursing until the time of her illness and held many responsible positions. After graduation she was in charge of the Accident Ward and later was assistant to the Directress of Nurses, in the Protestant Episcopal Hospital. She was Superintendent of the Kensington Hospital for Women in Philadelphia for many years, and at the time she was stricken was in charge of the Infirmary at the Leamy Home, Mt. Airy. Miss Parker was a fine woman and an excellent nurse and was beloved by all who knew her.

Mary E. Shutt, on October 12, 1929, at Marietta Memorial Hospital, Marietta, Ohio. Miss Shutt was fatally burned in a gas explosion in the Students' Home. She lived but a few hours. Miss Shutt was a member of the National League of Nursing Education. Her death was a great loss to the hospital and school.

Minnie Augusta Tapley (class of 1927, Bismarck Hospital, Bismarck, N. D.), on December 27, 1929, at the Bismarck Hospital, of mastoiditis and general septicemia. Miss Tapley did private nursing for one year after graduation, and since then had been employed by the Quain and Ramstad Clinic as surgical nurse at the Bismarck Hospital. She was an active member of her Alumnae Association, being vice president at the time of her death. Miss Tapley was greatly loved by all who knew her, and she is greatly missed.

Miscellany

About Books

[illegible] By Edward L. [illegible], and Others. 323 pages. [illegible] Company, New [illegible] Price, $3.

I[illegible] under forty-five should [illegible] trying to learn any[illegible] a belief or fear that he is too [illegible] learn it. Nor should he use [illegible] for not learning any[illegible] to learn. *If he fails in [illegible] due directly to age will very [illegible] the reason.*

[illegible] information is a [illegible] the findings of a series of [illegible] conducted by the [illegible] Educational Research of [illegible], Columbia Univer[illegible] guidance of Professor [illegible] his staff, and reported [illegible] the book entitled *Adult [illegible]*

[illegible] not prevented from [illegible], what does pre[illegible] A few of the reasons as [illegible] by this research group are [illegible]

[illegible] has lacked the capacity [illegible] thing. His desire to [illegible] to cause him to [illegible] it. The ways and [illegible], and would [illegible] to teach him that [illegible] or ideas or other [illegible] with the new ac[illegible] unable or unwilling [illegible] teachers of adults [illegible] them to learn at [illegible] is nearly the same [illegible] the same thing at [illegible]

[illegible] of this book is to [illegible] experimental [illegible] the ability of [illegible] acquire new knowledge and skills: it does not present, as might be expected from the title, any discussion of the special problems or methods of adult education.

The results of this research are very encouraging to the ambitious nurse who realizes that her cultural background or professional training is adequate; and it should serve to stimulate to renewed efforts nursing educators who are interested in "in-service" programs for staff education.

While this book is rather too technical for the average reader, for those who are able to interpret a technical and statistical treatment of experimental findings it furnishes a valuable and authoritative source of information upon a question of growing importance.

The adult student suffering from an inferiority complex because of age should profit by reading the chapter summaries where evidence piles up to banish all doubts concerning age as a significant cause of inability to learn. The cause will usually be found in lack of ambition or in uneconomical and ineffectual habits of study.

Maude B. Muse, R.N.

New York.

Practical Handbook for Diabetic Patients. By Abraham Rudy, M.D. 180 pages. Illustrated. M. Barrows and Company, Boston. 1929. Price, $2.

WRITTEN with the avowed purpose of supplying the necessary dietary information to diabetics, particularly those of foreign birth, this

handbook fully justifies its title. It should prove of general interest to nurses as well as the patients for whom it is primarily intended.

It is written in a clear, concise manner which makes for easy understanding. Unusual diagrams of food substitution charts make the working out of the diet a task which can be satisfactorily and easily accomplished by the patient himself.

Several chapters are worthy of particular notice. The one on "Hygiene" is most important; the chapters on "Diabetic Foods" and "Special Diabetic Foods" take up commercial products with which the patient usually is much concerned.

One part of the book is devoted to means of making variations in the prescribed diet, modifying it to fit in with the dietary laws and tastes of Jewish, Armenian, Swedish and Italian patients. Suggestions are also given for adopting the dietary to meet the requirements of the Lenten menu, the Passover, and various holidays, as well as the unusual demands encountered when traveling. One hundred and eighty recipes are planned to make use of permitted foods, and offer many suggestions for the practical preparation of the menus. The usual instructions regarding insulin treatment are included, as are also the customary percentage tables of food values, discussion of blood and urinary sugar, and explanation of the nature of the disease. Dr. Rudy's close association with Dr. Frederick M. Allen, who writes the introduction, and his work both at Boston City Hospital and Beth Israel Hospital, Boston, make him fully equipped to write such a work as this, and gives the assurance of accuracy.

The book is sincerely recommended to meet the needs of the class of patients for whom it is written, for it presents its material in as practical, simple and as nearly normal a manner as is consistent with scientific knowledge.

E. Baughman.

New York.

The Challenge of Chronic Diseases. By Ernest P. Boas, M.D., and Nicholas Michelson, M.D. 197 pages. The Macmillan Company, New York. 1929. Price, $2.50.

Doctor Boas and Doctor Michelson have condensed in a volume of 190 pages, including a bibliography, much valuable and thought-stimulating information concerning the needs of the chronic patient. In so far as the available facilities for his care are concerned, it is at once conceded that the chronic patient has much less to challenge either our interest or our scientific inquisitiveness than has the more dramatic and, in many respects, much more interesting acutely ill man or woman. When the battle waged between the invading organism and the body's resistive forces becomes a stalemate, chronicity results. Perhaps it is the very duration of the illness, changing in its clinical aspect apparently not at all from day to day, that produces a sociologic apathy on the part of the public generally, and a medical indifference specifically on the part of physicians.

Unfortunately, the resources of the patient are likely to be exhausted before a successful issue in this conquest between disease and the body's natural resistance is reached.

Hence, the financial requirements made upon a family for the care of one of its members who is suffering with a chronic disease are often of such magnitude that help from without must be sought. But to secure effectual aid in such a dilemma is

usually most difficult. The almshouse in many communities is the last resource of those who, reduced in financial circumstances, must provide for the prolonged expenditures incident upon chronic illness within the family group.

The classification which the authors of this volume make in regard to the types of chronically ill patients is largely drawn along lines dependent on the amount and variety of medical and nursing care required. An attempt is made to differentiate certain types of chronic disease due to degenerative processes in contradistinction to those produced by the wear and tear incident to the passage of threescore years. Such a classification is not particularly useful as an aid to the solution of the problem. It is about as easy to search successfully for agents which will cure chronic diseases as it is to locate the long lost fountain of youth which will remove the scars of old age. The end results of the presence of chronic disease, or of the wearing out of tissues are the same,—disability and family dependence. To be sure, patients who are not bedfast and who are suffering from cardiovascular or other chronic progressive processes may, for a number of years, be successfully supervised through the dispensary of the hospital.

A great variety of chronic ailments, therefore, irrespective of their cause, are capable of destroying earning power, and, of placing upon the community an economic problem which, after all, is as much its duty to meet as the care of those acutely ill. Generally, the care of such patients has been left to institutions supported by public funds. There are comparatively few private hospitals in this country with well organized and conducted chronic departments. Indeed, those that have recognised the importance of the need for convalescent care are rather the exception than the rule.

It would have been heartening, had the authors of this little volume devoted some space to a discussion of the relationship between an improperly supervised convalescence, and a preventable chronicity. It is more than a mere supposition that too many hospitals for the treatment of acute diseases, in their desire to shorten the average hospital stay of the patient, are making impossible the proper adjustment of the patient's bodily chemistry so that the period of convalescence is successfully passed and the danger of it merging into chronicity is evaded. Too great speeding up, therefore, of the hospital's turnover of patients, may tend to certain neurologic and cardiovascular defects which are much more difficult to cure than the original medical or surgical condition.

Another danger to be avoided appears to be the voluntary pauperization of those who are handicapped. That dread disease which comes from too long hospitalization, and which is expressed in a lack of desire to become self-supporting again, is almost as resistant to treatment as the actual presence of tissue pathology. Prevention of chronicity is certainly much more efficient than its cure. It can, of course, be taken for granted that it is most unwise to associate the acute with the chronic, in so far as institutional care is concerned. And this not only concerns itself with the economic aspect of the case, but also with its medical side.

In discussing some of the possibilities concerning the solution of the problem of the best means of caring for those afflicted with chronic disease, the authors suggest pensions for

the aged and infirm, sick insurance, and some interesting, but apparently idealistic, considerations relative to the prevention of poverty. The latter can only be brought about when there can be a standardization of many of those personal traits of industry and economy which are as intangible and as difficult of cultivation as are most other human character traits, the reason for the existence of which, man knoweth not!

It is wholly commendable to stress the desirability of preventing hospitalization, in so far as possible, of patients suffering with chronic disease. In some cities, there are to be found associations which have this desirable end as the reason for their existence. The Orphans' Guardian Society of Philadelphia, for example, has for many decades endeavored to keep intact the home circle, and to prevent its disruption by disease which produces poverty, or by poverty which is the result of disease.

The authors discuss, at not a little length, the structural and administrative requirements for a hospital for chronic diseases. While there are set forth in these almost one hundred pages many practical and interesting considerations which differentiate the conduct of the chronic from the acute hospital, it would seem that this chapter might have been somewhat abbreviated without detracting from the force of the dissertation. Like the poor, we will always have those suffering with chronic disease about us. There will be a never-ending army of the handicapped knocking at the doors of our country's institutions, and while the chronic patient is, perhaps with some justice, an annoyance to the acute hospital, yet one must plead for sanity and humanitarianism in so far as the handling of this type of patient is concerned. With the development of a newer understanding concerning the cause of chronic heart and kidney disease, will come preventive steps which may remove many hundreds of these cardiac cripples from our acute and chronic hospital wards. To be sure, disease due to senile and presenile states must be considered, for the time being at least, without the reach of the scientist.

At any rate, this volume has forcibly brought to the attention of the medical and hospital world, the injustice which is now being done to many patients disabled by chronic ailments, and may focus the attention of institutional boards generally upon the fact that the successful treatment of acute diseases is oftimes but the beginning of much more difficult, time-consuming, and costly processes.

JOSEPH C. DOANE, M.D.

Pennsylvania.

HISTORY OF LOUISIANA STATE NURSES' ASSOCIATION, 1904–1929. By Geneva A. Peters, R.N. 58 pages. Price, 50 cents.

THIS attractive booklet was prepared as a souvenir of the Silver Jubilee of the Association. It is much more than that. Its fifty odd pages are filled with the story of the devoted efforts of a growing band of women to advance the status and the service of nurses in this state. The struggle for legislation, the development of educational programs, the work of the Board of Nurse Examiners, and other nursing activities are described with pithy detail from original sources.

The little history should fill a place, not only in the homes of individual nurses, but in the libraries of all the schools of nursing in the state. When the history of nursing in this state comes to be written, it will be found that the State Association has already pioneered in an important field.

Official Directory

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* [illegible], 1930

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